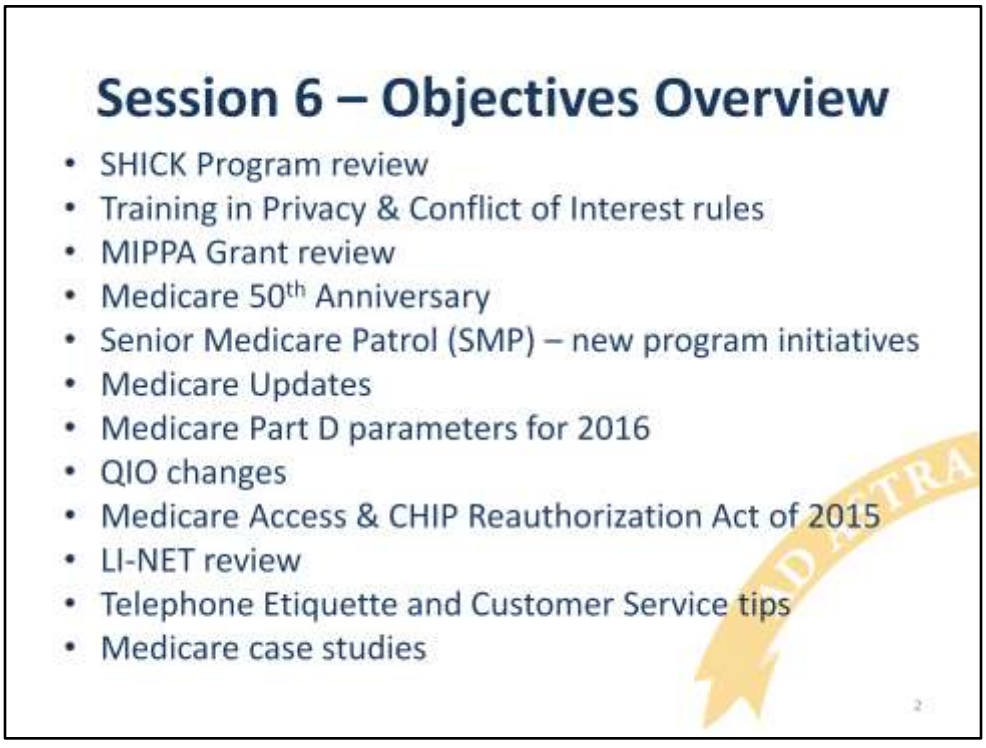
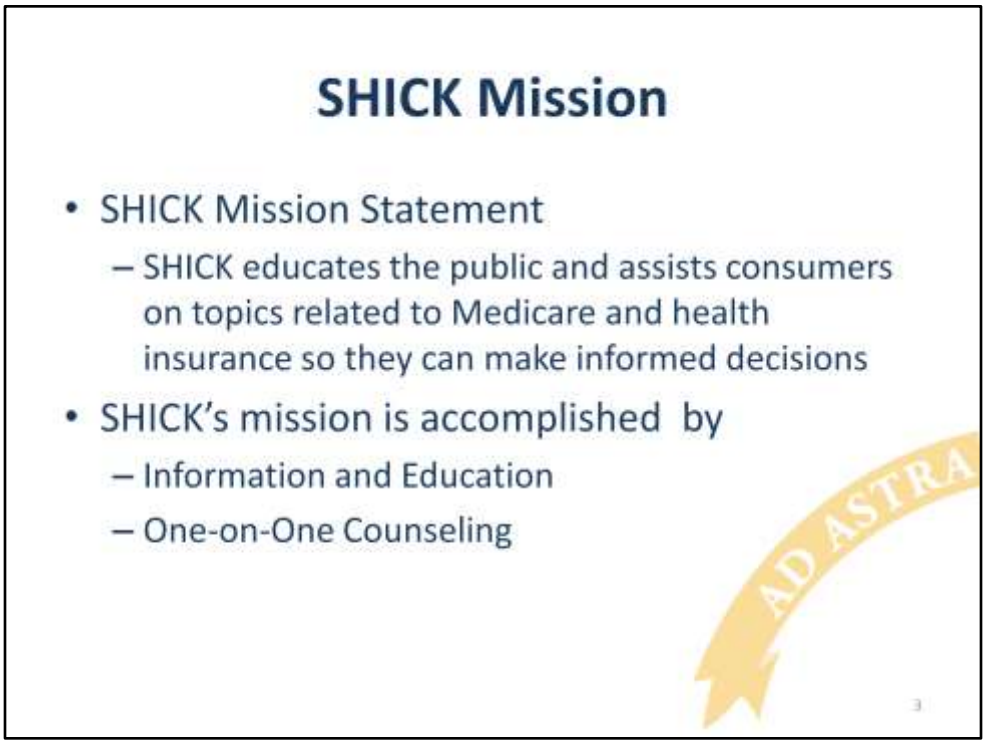
Kansas
Department for Aging and Disability Services

SHICK Annual Update Training
Session 6



- SHICK Program review
- Training in Privacy & Conflict of Interest rules
- MIPPA Grant review
- Medicare 50th Anniversary
- Senior Medicare Patrol (SMP) – new program initiatives
- Medicare Updates
- Medicare Part D parameters for 2016
- QIO changes
- Medicare Access & CHIP Reauthorization Act of 2015
- LI-NET review
- Telephone Etiquette and Customer Service tips
- Medicare case studies



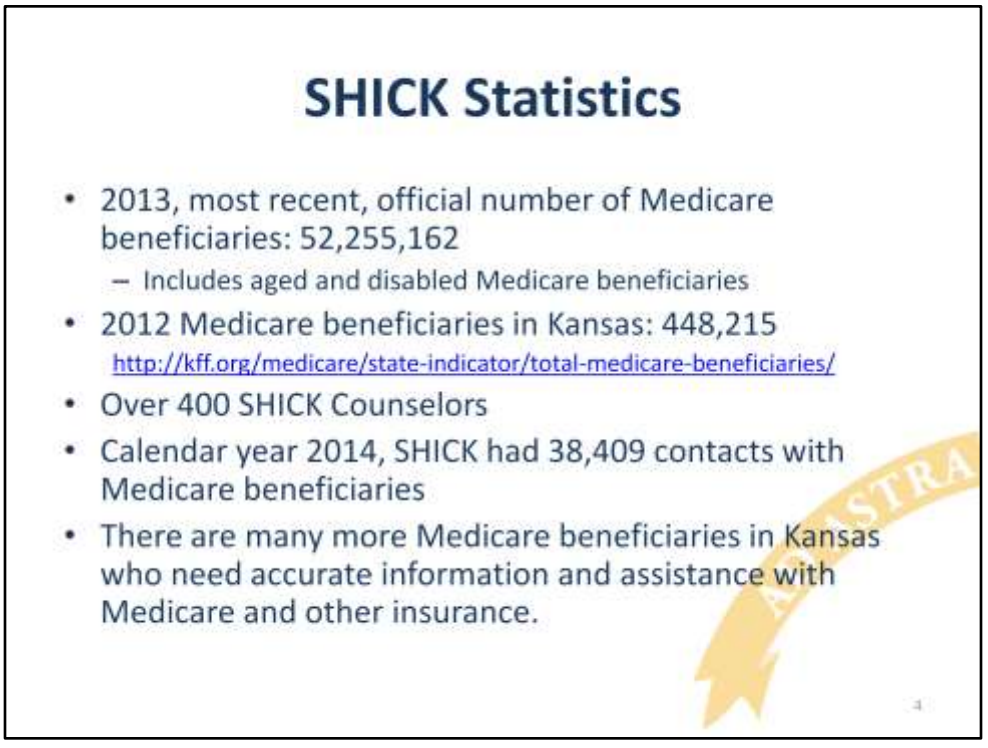
SHICK Mission Statement

SHICK educates the public and assists consumers on topics related to Medicare and health insurance so they can make informed decisions

SHICK's mission is accomplished by

Information and Education

One-on-One Counseling



2013, most recent, official number of Medicare beneficiaries: 52,255,162

Includes aged and disabled Medicare beneficiaries - Over 54 million in 2015

2012 Medicare beneficiaries in Kansas: 448,215

http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/

Over 400 SHICK Counselors

Calendar year 2014, SHICK had 38,409 contacts with Medicare beneficiaries

SHICK Counselor Responsibilities and Obligations

A SHICK counselor is expected to attend SHICK Update Training each year.

Must be completed in person during Initial Training and then can be completed in person or online every year after

A counselor is required to read and sign a Memorandum of Understanding each year agreeing to follow all program guidelines and regulations.

Is expected to track client contacts and public and media events.

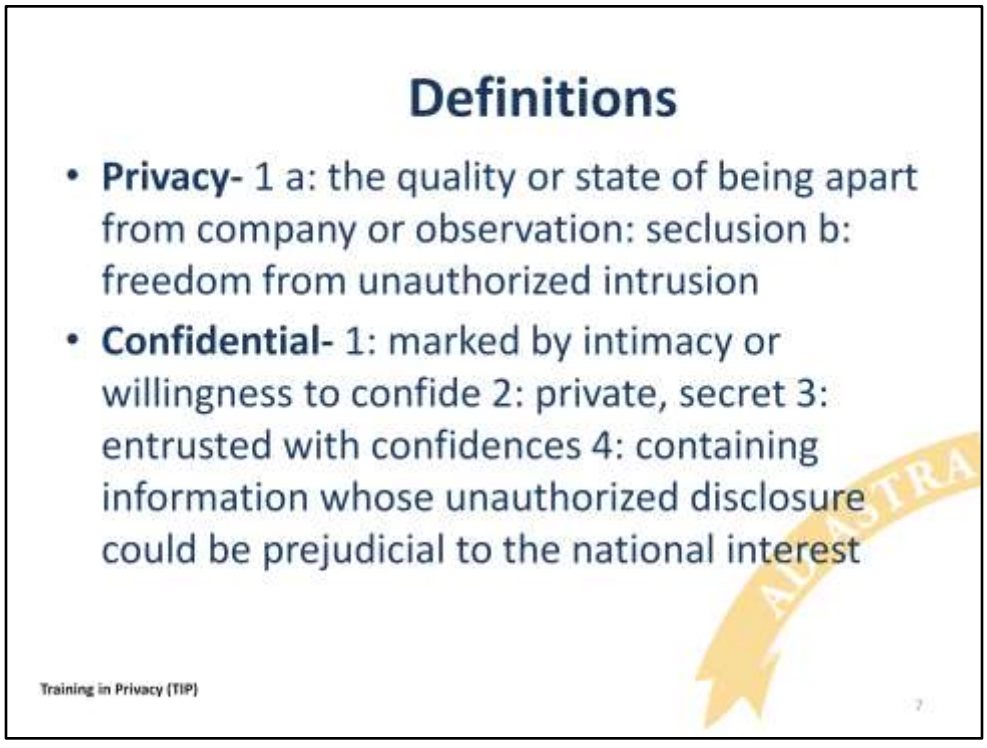
All SHICK counselors are required to complete annual training in Privacy practices and conflict of interest. This training is provided during the 24-hour Initial Training or Annual Update training.

See your SHICK Handbook

Chapter 1, Pages 1-14 through 1-17

Also referred to in the Memorandum of Understanding you signed (attached to your training record).

Introduced in New SHICK Counselor Training and reviewed every year.

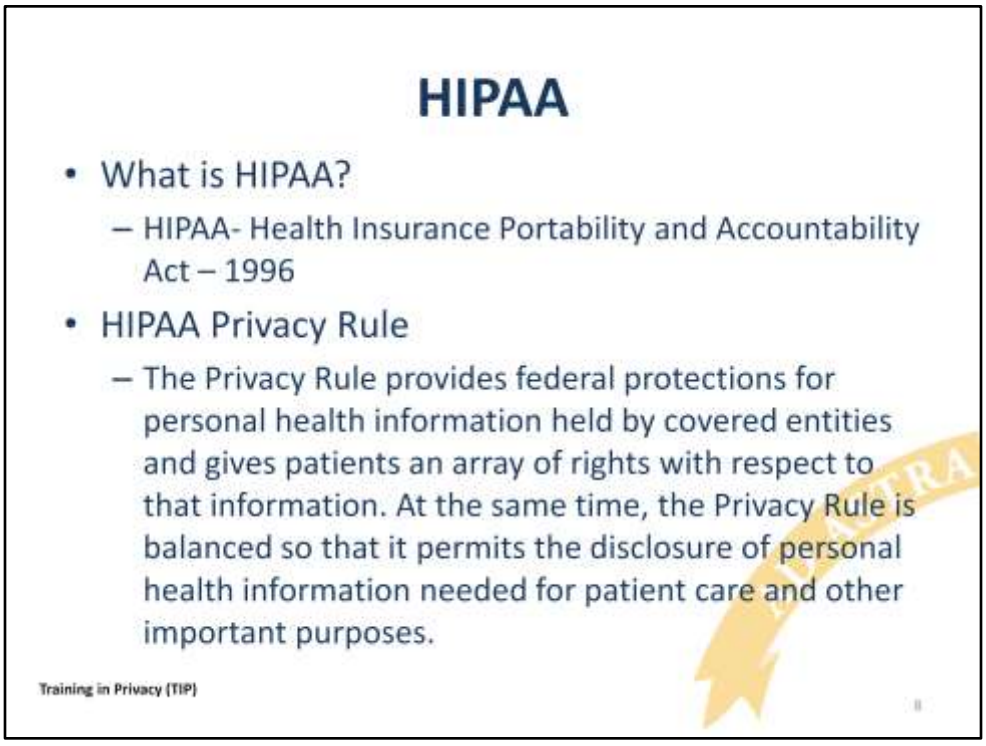


Definitions:

Privacy- According to Merriam-Webster Dictionary - 1 a**:** the quality or state of being apart from company or observation**: seclusion b:** freedom from unauthorized intrusion <one's right to *privacy*> 15th Century

Confidential- According to Merriam-Webster Dictionary - 1**:** marked by intimacy or willingness to **confide** <a *confidential* tone> 2**: private**, **secret** <*confidential* information> 3**:** entrusted with **confidences** <a *confidential* clerk> 4**:** containing information whose unauthorized disclosure could be prejudicial to the national interest - 1759

Gossip- According to Merriam-Webster Dictionary - 1 a *dialect British***: godparent b: companion**, **crony c:** a person who habitually reveals personal or sensational facts about others 2 a**:** rumor or report of an intimate nature **b:** a chatty talk **c:** the subject matter of gossip – Before the 12th Century



What is HIPAA?

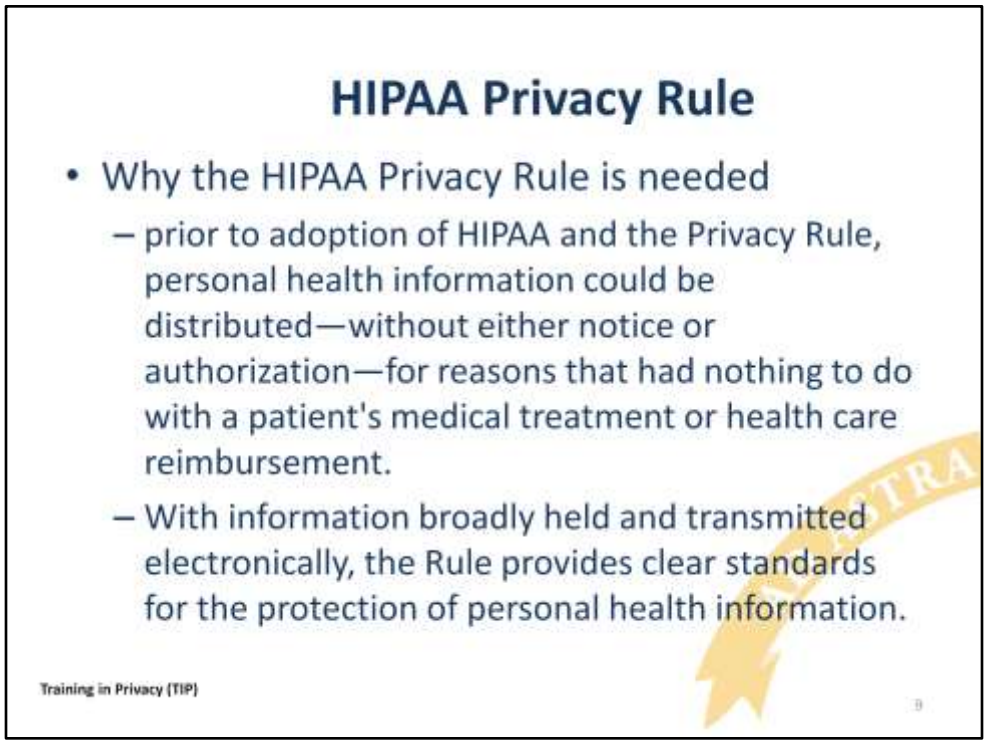
HIPAA- Health Insurance Portability and Accountability Act – 1996

HIPAA Privacy Rule

The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Your Health Information Is Protected By Federal Law

Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information.



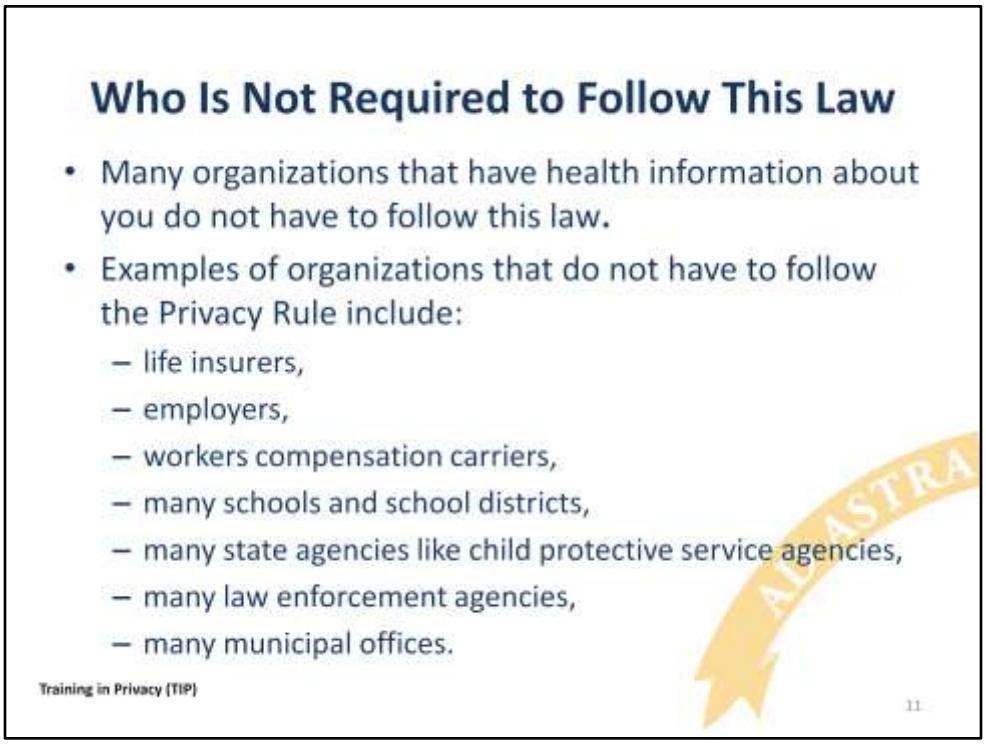
In enacting HIPAA, Congress mandated the establishment of Federal standards for the privacy of individually identifiable health information. When it comes to personal information that moves across hospitals, doctors' offices, insurers or third party payers, and State lines, we relied on a patchwork of Federal and State laws. Under the patchwork of laws existing prior to adoption of HIPAA and the Privacy Rule, personal health information could be distributed—without either notice or authorization—for reasons that had nothing to do with a patient's medical treatment or health care reimbursement. For example, unless otherwise forbidden by State or local law, without the Privacy Rule patient information held by a health plan could, without the patient's permission, be passed on to a lender who could then deny the patient's application for a home mortgage or a credit card, or to an employer who could use it in personnel decisions. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. State laws which provide stronger privacy protections continue to apply over and above the Federal privacy standards.
Health care providers have a strong tradition of safeguarding private health information. However, in today's world, the old system of paper records in locked filing cabinets is not enough. With information broadly held and transmitted electronically, the Rule provides clear standards for the protection of personal health information.

Who Must Follow the HIPAA Privacy Rule

We call the entities that must follow the Privacy Rule "***covered entities***." Individuals, organizations, and agencies that met the definition of a covered entity under HIPAA must comply with the Privacy Rule's requirements to protect the privacy of health information and must provide individuals with certain rights with respect to their health information. If an entity is not a covered entity, it does not have to comply with the Privacy Rule.

Covered entities include:

- **Health Plans**, including health insurance companies, HMOs, company health plans, and certain government programs that pay for health care, such as Medicare and Medicaid.
- **Most Health Care Providers**—those that conduct certain business electronically, such as electronically billing your health insurance—including most doctors, clinics, hospitals, psychologists, chiropractors, nursing homes, pharmacies, and dentists.
- **Health Care Clearinghouses**—entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content), or vice versa.
- Hybrid Entities
    - A single legal entity where only some of the divisions or programs meet the definition of a Covered Entity.
    - KDHE and KDADS are examples of Hybrid Entities

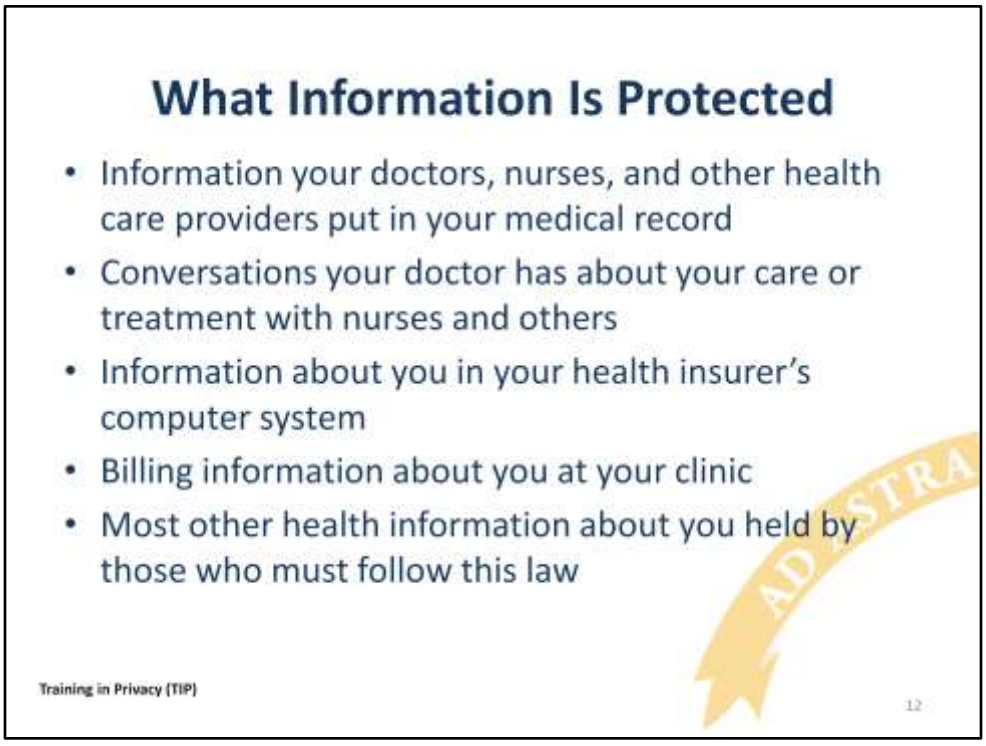


Who Is Not Required to Follow This Law

Many organizations that have health information about you do not have to follow this law**.**

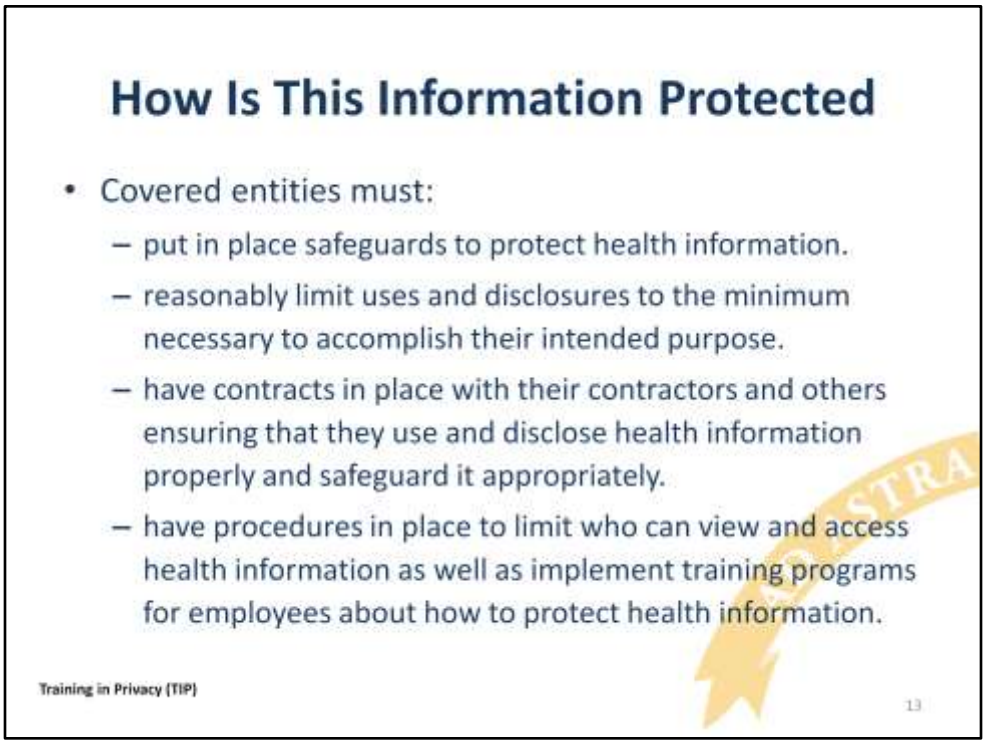
Examples of organizations that do not have to follow the Privacy Rule include:

- life insurers,
- employers,
- workers compensation carriers,
- many schools and school districts,
- many state agencies like child protective service agencies,
- many law enforcement agencies,
- many municipal offices.



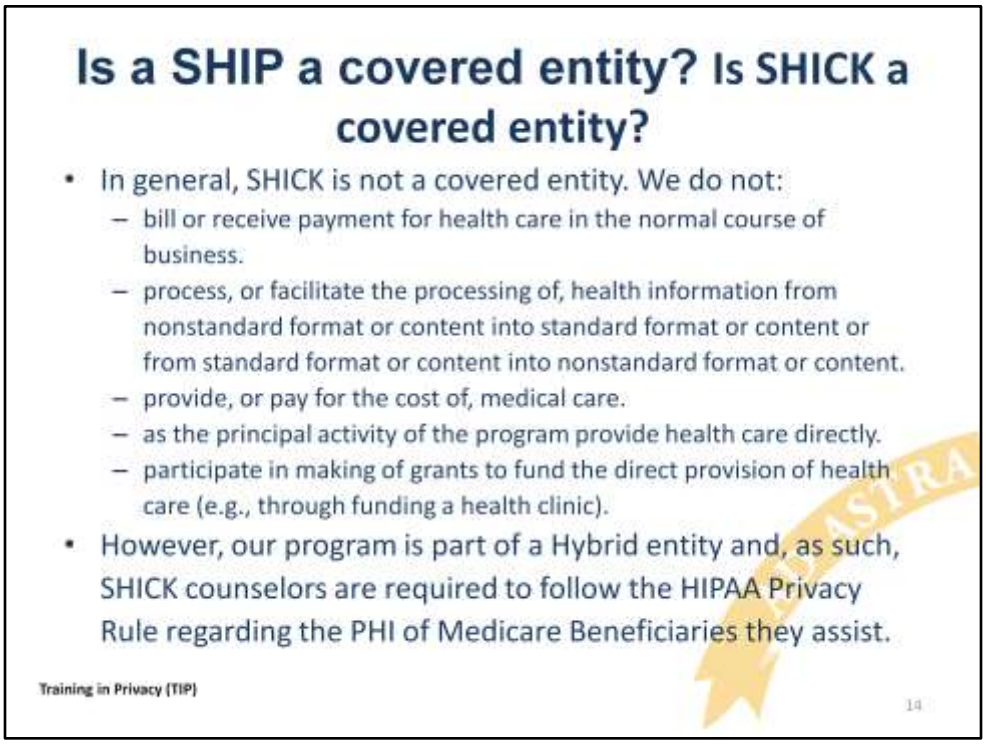
What Information Is Protected

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law



How Is This Information Protected

- Covered entities must put in place safeguards to protect your health information.
- Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
- Covered entities must have contracts in place with their contractors and others ensuring that they use and disclose your health information properly and safeguard it appropriately.
- Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.

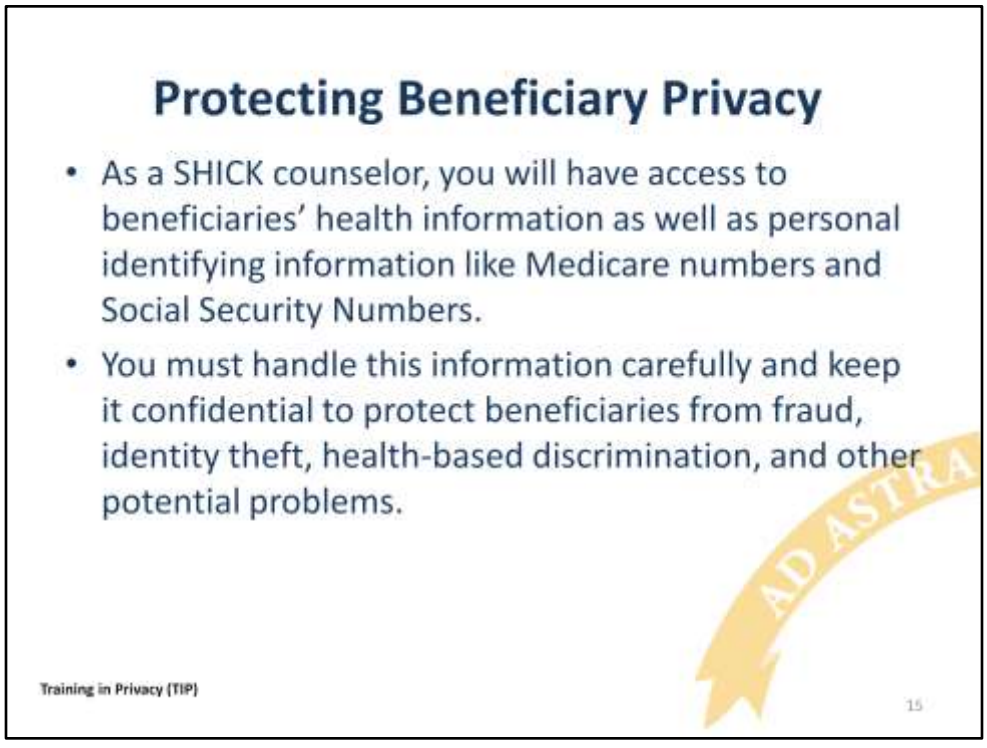


Is a SHIP a covered entity? Is SHICK a covered entity?

In general, SHICK is not a covered entity.

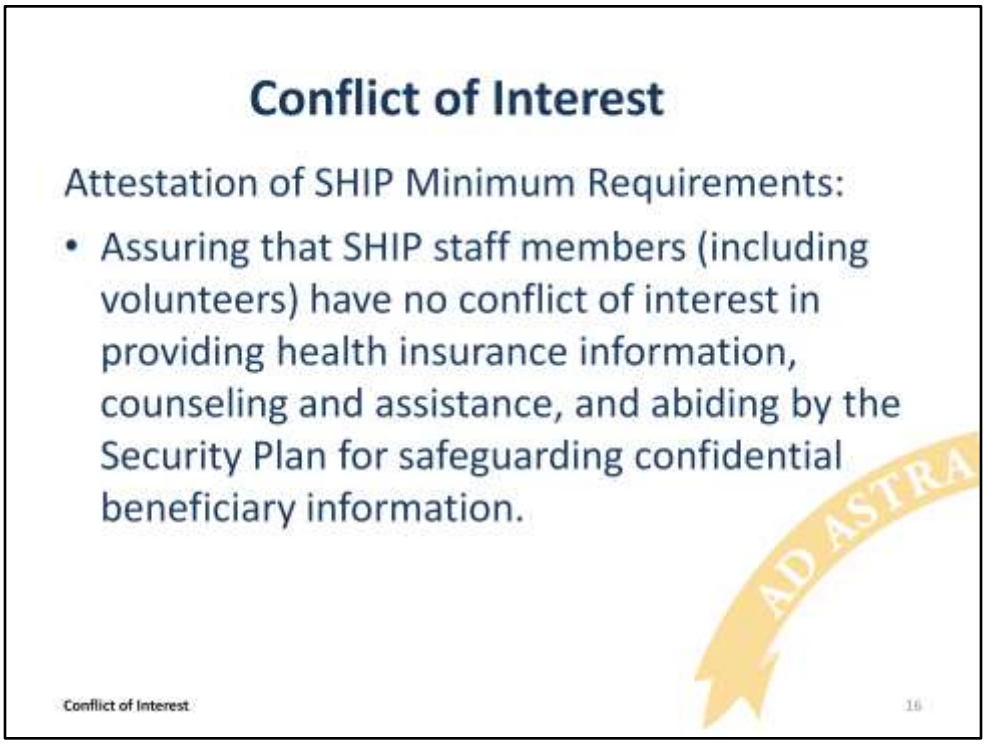
- We do not bill or receive payment for health care in the normal course of business.
- We do not process, or facilitate the processing of, health information from nonstandard format or content into standard format or content or from standard format or content into nonstandard format or content.
- We do not provide, or pay for the cost of, medical care.
- We do not as the principal activity of the program provide health care directly.
- We do not participate in making of grants to fund the direct provision of health care (e.g., through funding a health clinic).

However, our program is part of a Hybrid entity and, as such, SHICK counselors are required to follow the HIPAA Privacy Rule regarding the PHI of Medicare Beneficiaries they assist.



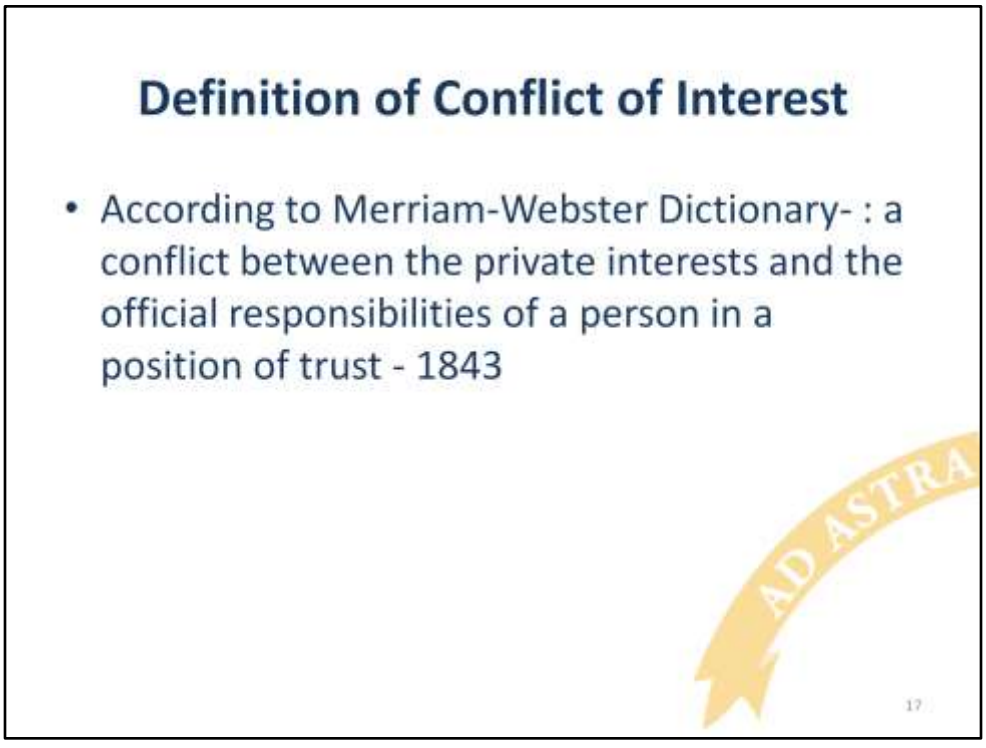
Protecting Beneficiary Privacy
As a SHICK counselor, you will have access to beneficiaries' health information as well as personal identifying information like Medicare numbers and Social Security Numbers. You must handle this information carefully and keep it confidential to protect beneficiaries from fraud, identity theft, health-based discrimination, and other potential problems.

- Only collect the information you need to provide the help the beneficiary has asked for (for example, you don't need a list of medications to help someone enroll in a Medigap plan).
- Only share beneficiary information with people or agencies who are directly involved in providing the help the beneficiary has asked for (like a Part D plan, for example).
- Don't keep beneficiary information on a laptop or in a file that you take out of the office with you.
- Don't leave beneficiary information out on a desk or up on a computer screen where it can be seen by others.
- Conduct counseling sessions in private where personal information shared by the beneficiary won't be overheard by others.
- If you believe beneficiary information has been lost, stolen, or misused, contact your SHICK Coordinator immediately.
- If you believe a beneficiary has been the victim of fraud or identity theft, contact your SHICK Coordinator and/or the Kansas SMP Coordinator immediately.

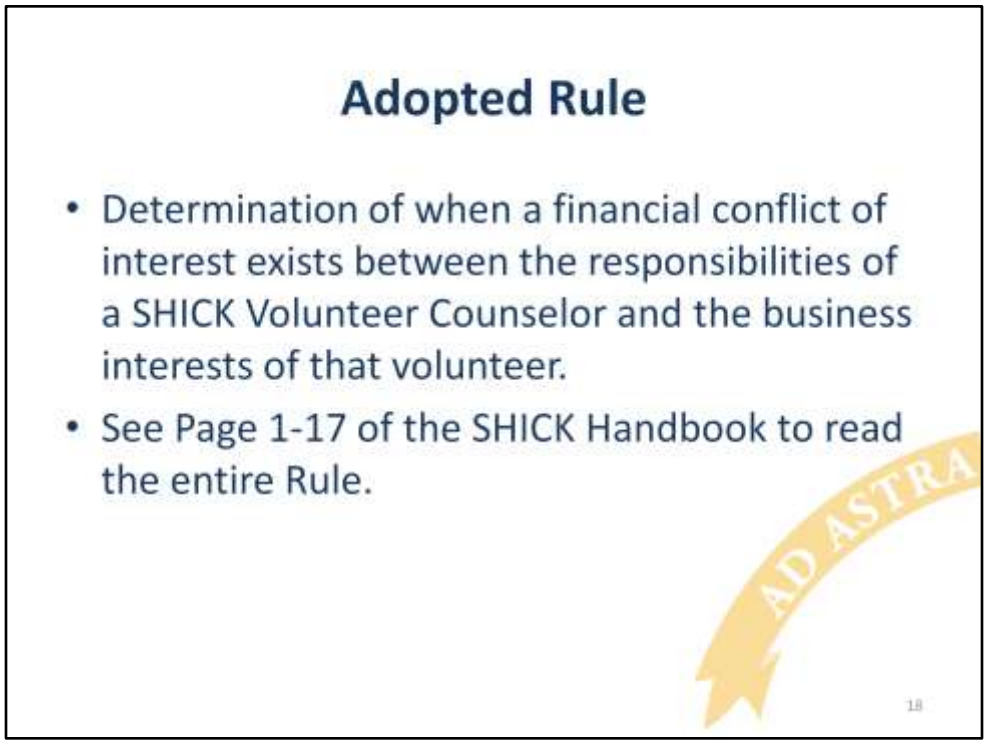


Attestation of SHIP Minimum Requirements:

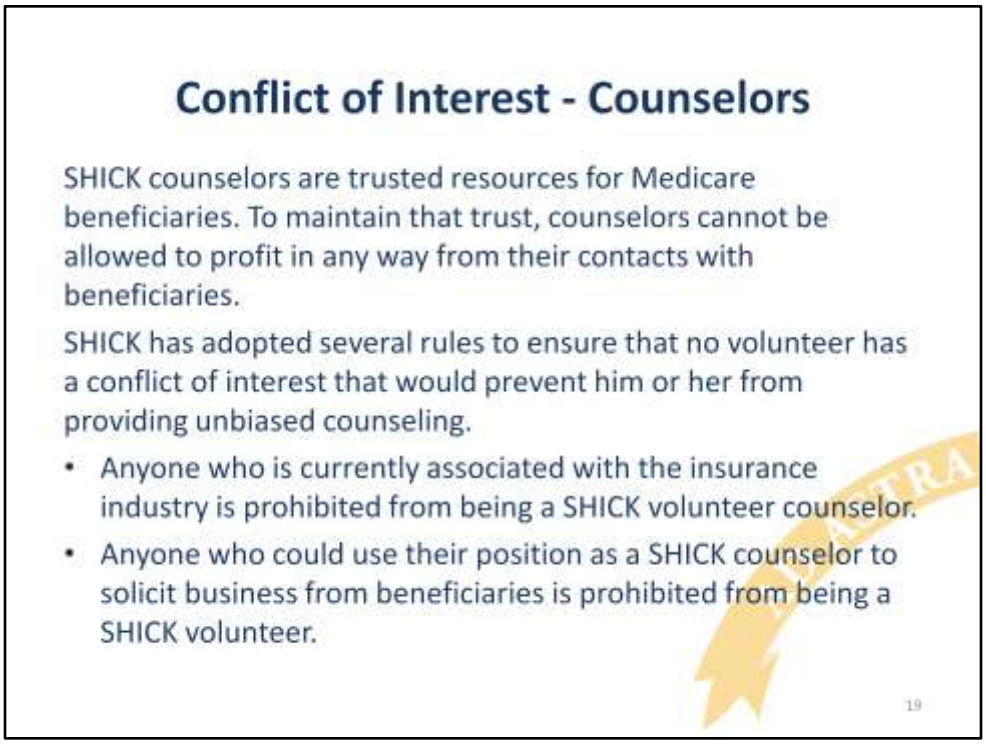
Assuring that SHIP staff members (including volunteers) have no conflict of interest in providing health insurance information, counseling and assistance, and abiding by the Security Plan for safeguarding confidential beneficiary information.



According to Merriam-Webster Dictionary- : a conflict between the private interests and the official responsibilities of a person in a position of trust - 1843

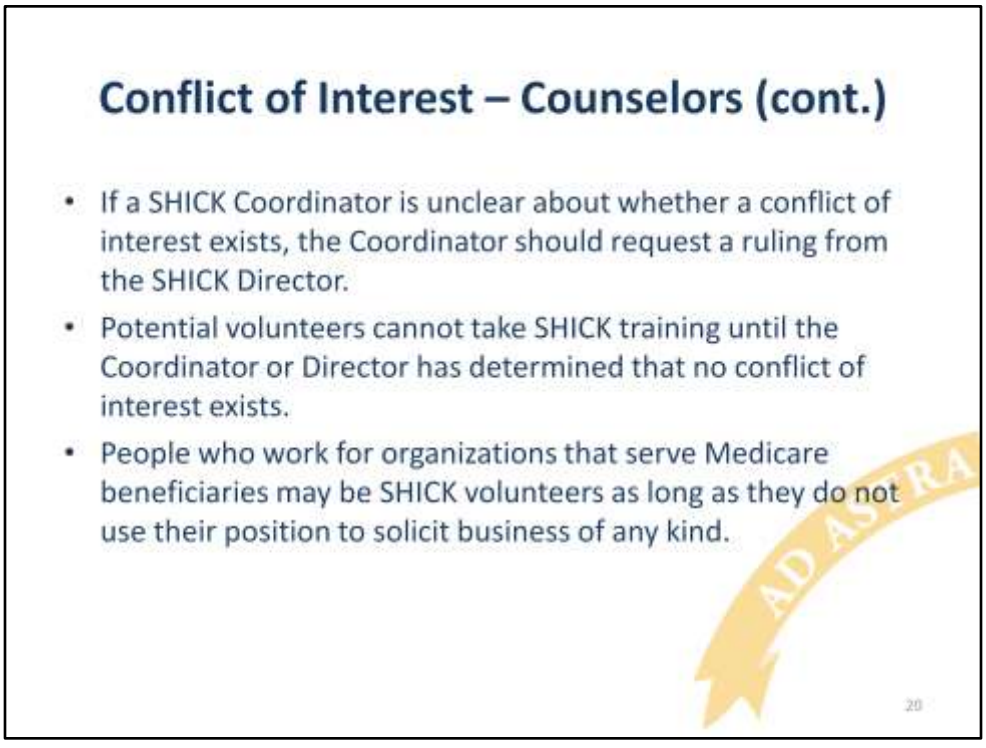


- When screening potential SHICK Volunteer Counselors, Volunteer Coordinators should make a determination as to whether applicants have a financial conflict of interest. Obviously, anyone who is currently associated with the insurance industry in any financial capacity is strictly prohibited from being a SHICK volunteer counselor by law. As well, all individuals who could, even remotely, use their position as a SHICK Counselor as an avenue to solicit business from seniors are prohibited from becoming a SHICK Volunteer.
- If a situation arises where it is unclear to a SHICK Coordinator whether a financial conflict of interest exists, the Coordinator should forward a request to the SHICK Director for a determination of whether such a conflict of interest exists. All final decisions remain with the Director.
- No volunteer applicant shall take any SHICK training until the Coordinator or Director has determined that no financial conflict of interest exists.
- People who have positions with agencies and other organizations who serve older people are not excluded from being a SHICK volunteer as long as they do not use their position to solicit business of any kind from Medicare beneficiaries.
- The purpose of this rule is to insure that volunteers do not have any financial conflicts of interest between their personal business interests and their responsibilities as a counselor which might compromise their responsibility to provide unbiased information to Medicare beneficiaries.



SHICK counselors are trusted resources for Medicare beneficiaries. To maintain that trust, counselors cannot be allowed to profit in any way from their contacts with beneficiaries. SHICK has adopted several rules to ensure that no volunteer has a conflict of interest that would prevent him or her from providing unbiased counseling.

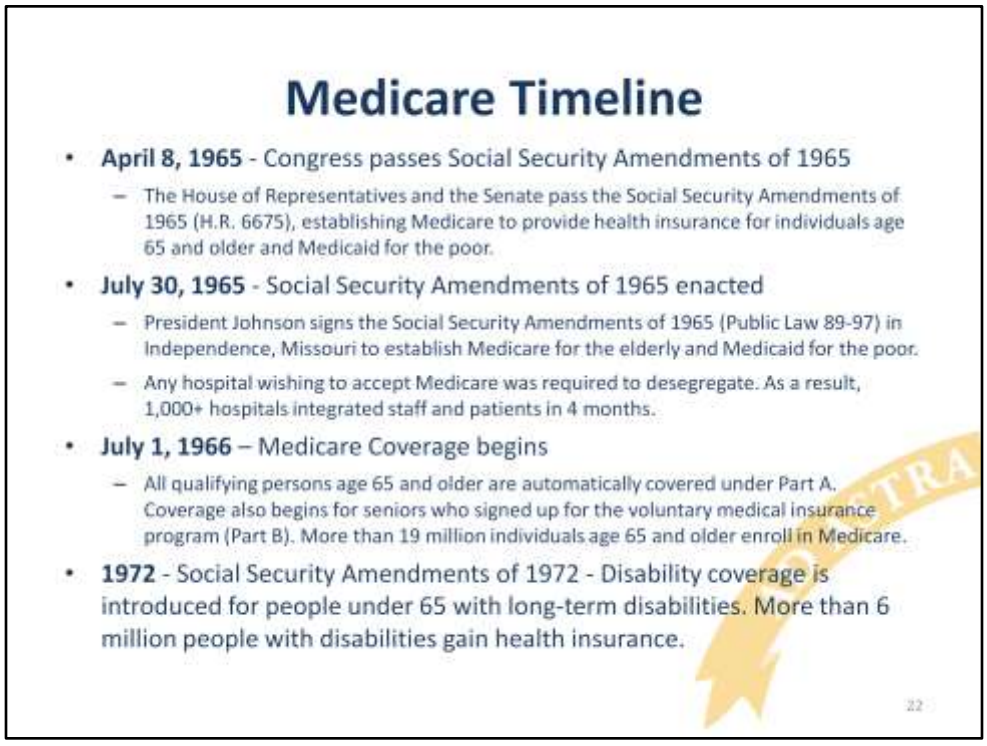
- Anyone who is currently associated with the insurance industry is prohibited from being a SHICK volunteer counselor.



- Anyone who could use their position as a SHICK counselor to solicit business from beneficiaries is prohibited from being a SHICK volunteer.
- If a SHICK Coordinator is unclear about whether a conflict of interest exists, the Coordinator should request a ruling from the SHICK Director.
- Potential volunteers cannot take SHICK training until the Coordinator or Director has determined that no conflict of interest exists.
- People who work for organizations that serve Medicare beneficiaries may be SHICK volunteers as long as they do not use their position to solicit business of any kind.

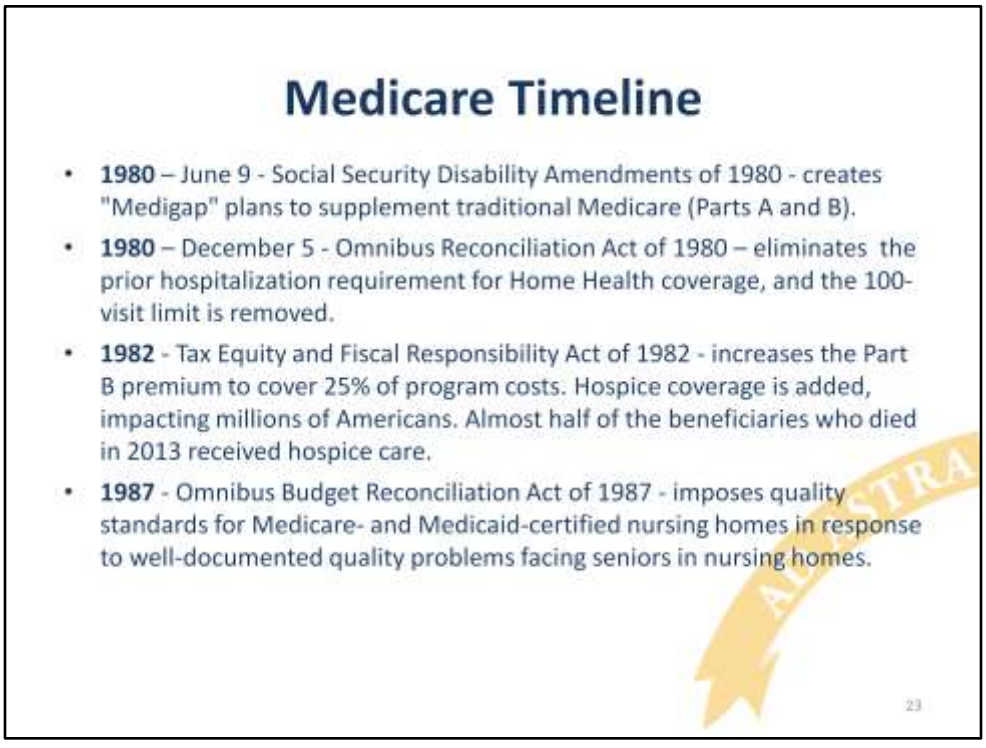
Social Security Amendments of 1965 enacted on July 30, 1965
established Medicare for the elderly and Medicaid for the poor
Medicare coverage began July 1, 1966
More than 19 million people enrolled in Medicare's first year
Access to care increased by 1/3
Poverty among older and disabled Americans decreased by nearly 2/3
Personal economic security increased for older people and their families

FUN FACTS
President Harry Truman was the first official Medicare enrollee.
The monthly Part B premium was only $3.00.

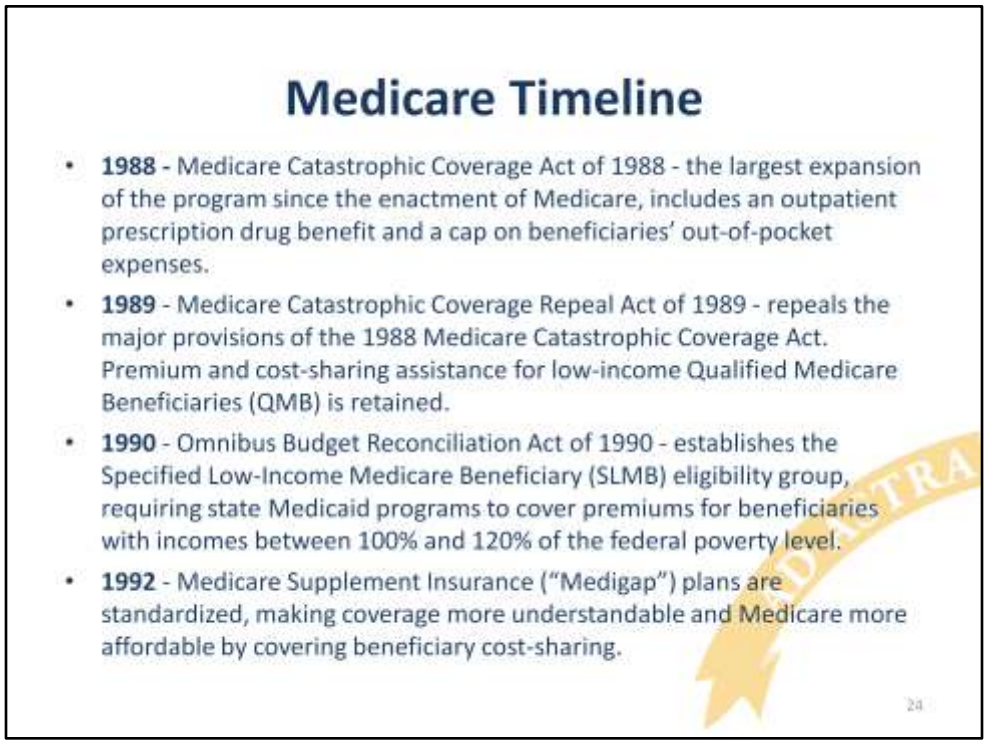


April 8, 1965 - Congress passes Social Security Amendments of 1965
Prior to the establishment of Medicare, in particular, half of all people age 65 and older lacked health insurance, limiting accessibility and affordability to an entire age demographic of Americans. The Social Security Amendments of 1965, as well as the Older Americans Act of 1965 (Public Law 89-73), which created several agencies dedicated to the needs of older people, were major legislative advancements for health care and delivery services in the United States.
July 30, 1965 - Social Security Amendments of 1965 enacted
The law is enacted in the presence of Harry S. Truman, who advocated for such legislation in a message to Congress in 1945. President Truman is the first to enroll in Medicare.

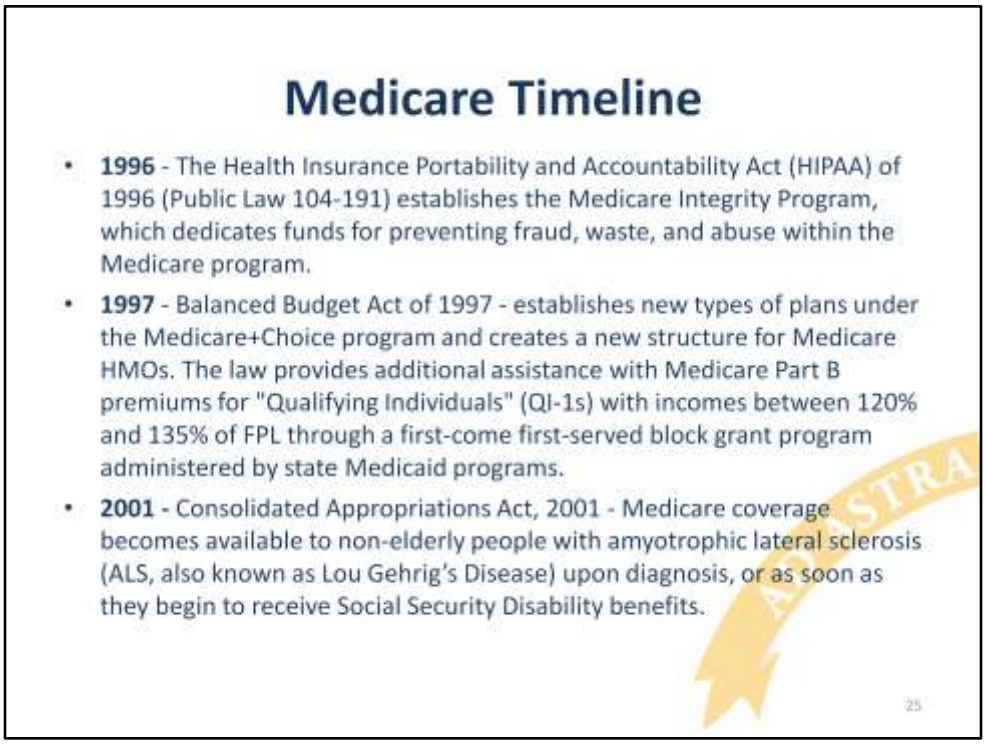
July 1, 1966 – Medicare Coverage begins - All qualifying persons age 65 and older are automatically covered under Part A. Coverage also begins for seniors who signed up for the voluntary medical insurance program (Part B). More than 19 million individuals age 65 and older enroll in Medicare.
1972 - President Nixon signs the Social Security Amendments of 1972 (Public Law 92-603), the first major adjustment to Medicare after its enactment. Medicare eligibility is extended to individuals under age 65 with long-term disabilities (and who received Social Security Disability Insurance [SSDI] payments for two years) and to individuals with end-stage renal disease (ESRD). The amendments also establish Professional Standards Review Organizations (PSROs) to review patient care, encourage enrollment in health maintenance organizations (HMOs), and give Medicare the authority to conduct demonstration programs. Medicare benefits are expanded to include some chiropractic services, speech therapy, and physical therapy.



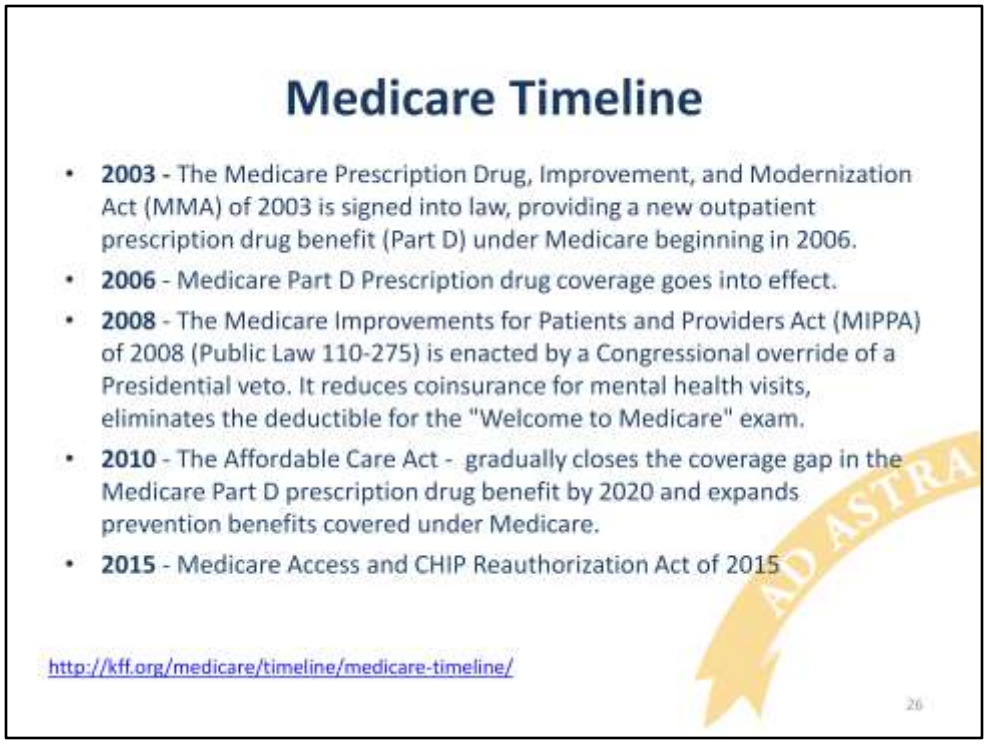
1980 – June 9 - Social Security Disability Amendments of 1980 - The "Baucus Amendment" (Sec. 507 of the Amendments), named after its main sponsor, Senator Max Baucus, brings Medicare supplement insurance ("Medigap") under federal oversight and establishes a voluntary certification program for Medigap policies.
1980 – December 5 - Omnibus Reconciliation Act of 1980 – eliminates the prior hospitalization requirement for Home Health coverage, and the 100-visit limit is removed.
1982 - Tax Equity and Fiscal Responsibility Act of 1982 - increases the Part B premium to cover 25% of program costs. Hospice coverage is added, impacting millions of Americans. Almost half of the beneficiaries who died in 2013 received hospice care. TEFRA facilitates HMOs' participation in the Medicare program and establishes a risk-based prospective payment system for these plans. The Act also expands HCFA's quality oversight efforts by replacing Professional Standards Review Organizations (PSROs) with Peer Review Organizations (PROs), imposes a ceiling on the amount Medicare would pay for a hospital discharge, and requires the Department of Health and Human Services (HHS) to submit a plan for prospective payments to hospitals and nursing homes. TEFRA requires federal employees to begin paying the Medicare Part A (Hospital Insurance) payroll tax.
1987 - Omnibus Budget Reconciliation Act of 1987 - imposes quality standards for Medicare- and Medicaid-certified nursing homes in response to well-documented quality problems facing seniors in nursing homes. It also modifies payments to providers under Medicare as part of the deficit reduction legislation.



1988 -Medicare Catastrophic Coverage Act of 1988 - the largest expansion of the program since the enactment of Medicare, includes an outpatient prescription drug benefit and a cap on beneficiaries' out-of-pocket expenses.
It also expands hospital and skilled nursing facility (SNF) benefits by removing time limits on most hospital service coverage, and requires Medicaid to cover Medicare premiums and cost-sharing for Medicare beneficiaries with incomes below 100% of the federal poverty level (FPL). These "Qualified Medicare Beneficiaries" (QMB) must also pass an asset test confirming that they have a limited amount of financial resources.
1989 - Medicare Catastrophic Coverage Repeal Act of 1989 - repeals the major provisions of the 1988 Medicare Catastrophic Coverage Act. Premium and cost-sharing assistance for low-income Qualified Medicare Beneficiaries (QMB) is retained.
1990 - Omnibus Budget Reconciliation Act of 1990 - establishes the Specified Low-Income Medicare Beneficiary (SLMB) eligibility group, requiring state Medicaid programs to cover premiums for beneficiaries with incomes between 100% and 120% of the federal poverty level.
Medicare is expanded to cover mammography screening and partial hospitalization services in community mental health centers. Federal standards are established for Medigap policies, including standardized benefit packages and minimum loss ratios, replacing the voluntary certification system.
1992 - Medicare Supplement Insurance ("Medigap") plans are standardized, making coverage more understandable and Medicare more affordable by covering beneficiary cost-sharing.



1996 - The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191) establishes the Medicare Integrity Program, which dedicates funds for preventing fraud, waste, and abuse within the Medicare program.
1997 - Balanced Budget Act of 1997 - establishes new types of plans under the Medicare+Choice program and creates a new structure for Medicare HMOs. The law provides additional assistance with Medicare Part B premiums for "Qualifying Individuals" (QI-1s) with incomes between 120% and 135% of FPL through a first-come first-served block grant program administered by state Medicaid programs.
The law also provides for partial assistance for beneficiaries with incomes between 135% and 175% of FPL (QI-2s), but the QI-2 program ended December 31, 2002 after non-renewal. The BBA also establishes the National Bipartisan Commission on the Future of Medicare and the Medicare Payment Advisory Commission (replacing the Prospective Payment Assessment Commission and the Physician Payment Review Commission). In order to address the increase in Medicare payments to physicians, the BBA establishes the Sustainable Growth Rate (SGR) for determining whether and by how much the physician fee schedule should be updated.
2001 - Consolidated Appropriations Act, 2001 - Medicare coverage becomes available to non-elderly people with amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's Disease) upon diagnosis, or as soon as they begin to receive Social Security Disability benefits.



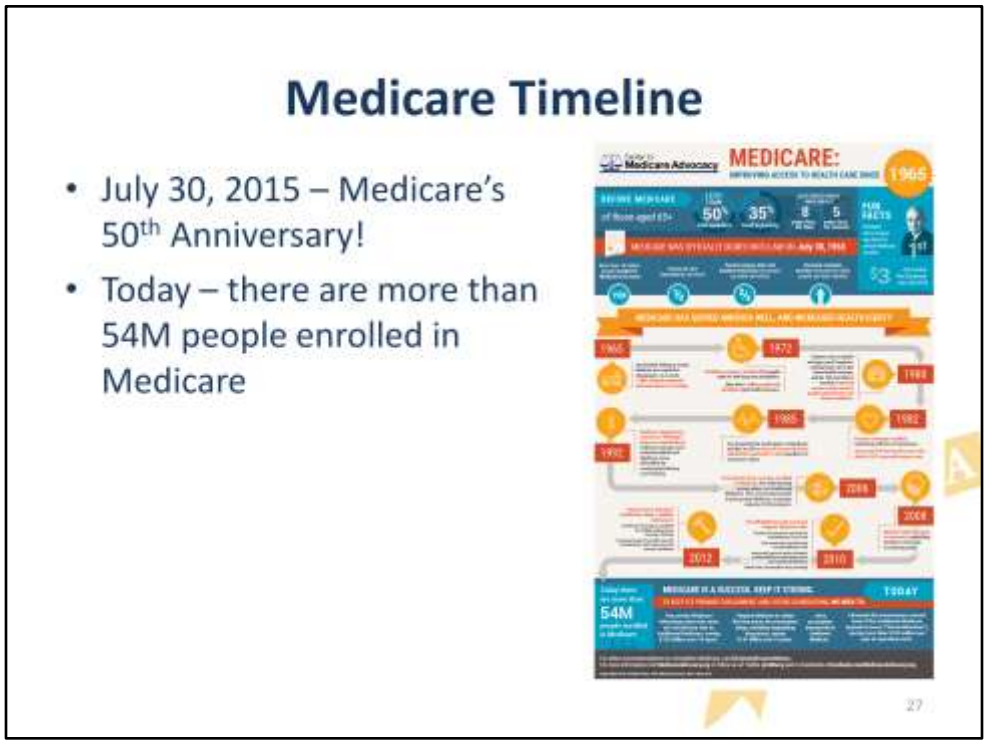
2003 - The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 is signed into law, providing a new outpatient prescription drug benefit (Part D) under Medicare beginning in 2006. The MMA also establishes a new income-related Part B premium for beneficiaries with higher incomes (beginning in 2007), and renames the Medicare+Choice program "Medicare Advantage."

2006 - Medicare Part D Prescription drug coverage goes into effect.

2008 - The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (Public Law 110-275) is enacted by a Congressional override of a Presidential veto. It reduces coinsurance for mental health visits, eliminates the deductible for the "Welcome to Medicare" exam. The law also reduces coinsurance for mental health visits, eliminates the deductible for the "Welcome to Medicare" exam, increases allowable resources for low-income beneficiaries applying for the Medicare Savings Programs (MSPs), and modifies the definition of "excludable assets" in determining Low-Income Subsidy (LIS)/"Extra Help" program eligibility.

2010 - The Affordable Care Act - gradually closes the coverage gap in the Medicare Part D prescription drug benefit by 2020 and expands prevention benefits covered under Medicare.
It also introduces new programs designed to improve the quality and delivery of care to people covered by Medicare, such as Accountable Care Organizations (ACOs). The ACA includes provisions to reduce the growth in Medicare payments to health care providers and Medicare Advantage plans, and for the first time, provides bonus payments to Medicare Advantage plans based on the plans' quality ratings. The ACA also includes other provisions designed to slow the growth in Medicare spending and strengthen the solvency of the Medicare Hospital Insurance trust fund, including authorizing the Independent Payment Advisory Board (IPAB). The law establishes a new income-related premium for Part D drug coverage (incomes more than $85,000/individual; $170,000/couple in 2011) and raises the Part A payroll tax for high-income beneficiaries (incomes more than $200,000/individual and $250,000/couple in 2013).

2015 - Medicare Access and CHIP Reauthorization Act of 2015



July 30, 2015 – Medicare's 50th Anniversary!

As of 2015, Medicare has played a vital role in providing financial security to older Americans and those with disabilities. The program covers 54 million beneficiaries and in 2012, accounted for 20% of national health spending. Throughout the course of its lifetime, Medicare has undergone several changes, both small and large. Many of these changes - particularly provisions included in the Affordable Care Act - will continue to be phased in over time. As baby boomers age, the Medicare population continues to grow, and the program continues to evolve.

http://kff.org/medicare/timeline/medicare-timeline/

Kansas Senior Medicare Patrol

Take Charge…

Help Prevent Health Care Fraud and Abuse!

You might be wondering, why should I care about Medicare fraud? Well, Medicare fraud, errors, and abuse affect everyone!

- Each year, Medicare loses BILLIONS of taxpayer dollars to improper claims.
- This puts the Medicare trust fund at risk for everyone and affects the future of the Medicare program.

Medicare fraud, errors, and abuse also affect current Medicare beneficiaries because they result in higher Medicare premiums and waste money that could be used to increase and improve health care services.

Medicare fraud, errors, and abuse can also cause serious personal consequences for beneficiaries, such as medical identity theft, negative health impacts, and personal financial losses.

Medical Identity Theft

Medical identity theft occurs when a beneficiary's Medicare number is misused, either by a provider, a supplier, or by someone posing as the real beneficiary in order to receive medical care. Such Medicare numbers are considered "compromised." Medicare numbers are for life, even if stolen or misused, so a beneficiary whose number is compromised may be affected forever by false claims against his or her Medicare number.

Health Impact

Receiving health care from a fraudulent provider can mean the quality of the care is poor, the intervention is not medically necessary, or worse: The intervention is actually harmful. A beneficiary may later receive improper medical treatment from legitimate providers as a result of inaccurate medical records that contain:

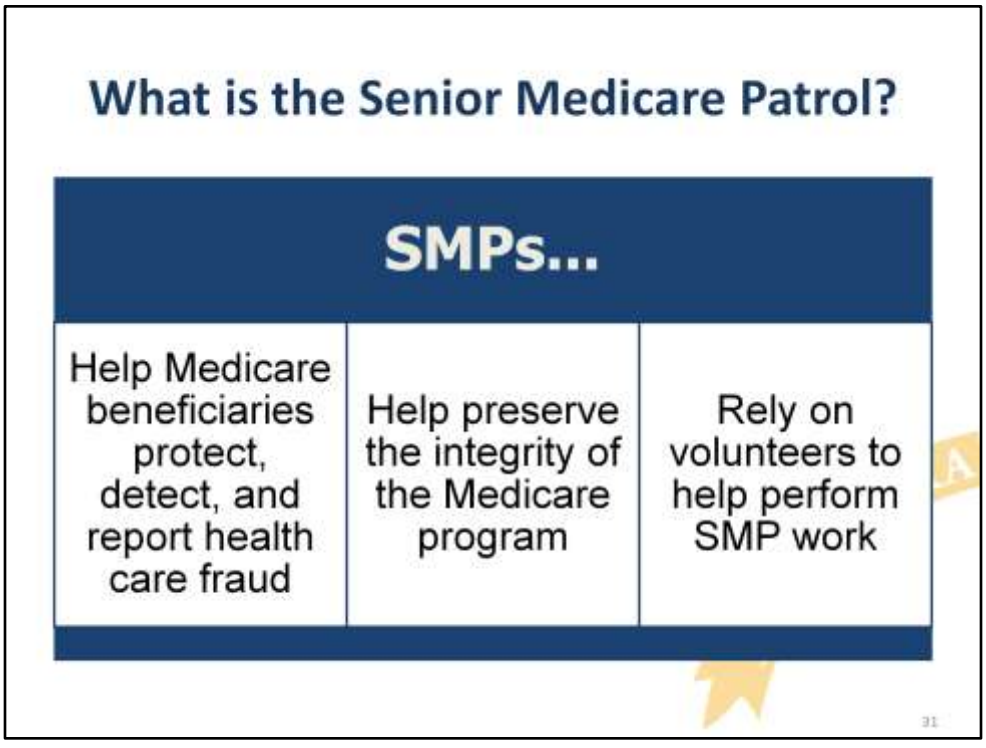
- False diagnoses
- Records showing treatments that never occurred
- Misinformation about allergies
- Incorrect lab results

Additionally, because of inaccurate or fraudulent claims to Medicare, beneficiaries may be denied needed Medicare benefits. For example, some products and services have limits. If Medicare thinks such products and services were already provided, they will deny payment.

Personal Financial Losses

Medicare fraud, errors, and abuse can all result in higher out-of-pocket costs for beneficiaries, such as copayments for health care services that were never provided, were excessive, or were medically unnecessary. Beneficiaries may also find themselves stuck with bills for services from providers who should have billed Medicare but instead billed the beneficiary for the entire cost of that service. Finally, because Medicare numbers also contain Social Security numbers, financial fraud can be a side effect of having one's Medicare number compromised. Medicare numbers are as valuable as Social Security numbers to thieves who wish to set up credit card accounts with someone else's identity.

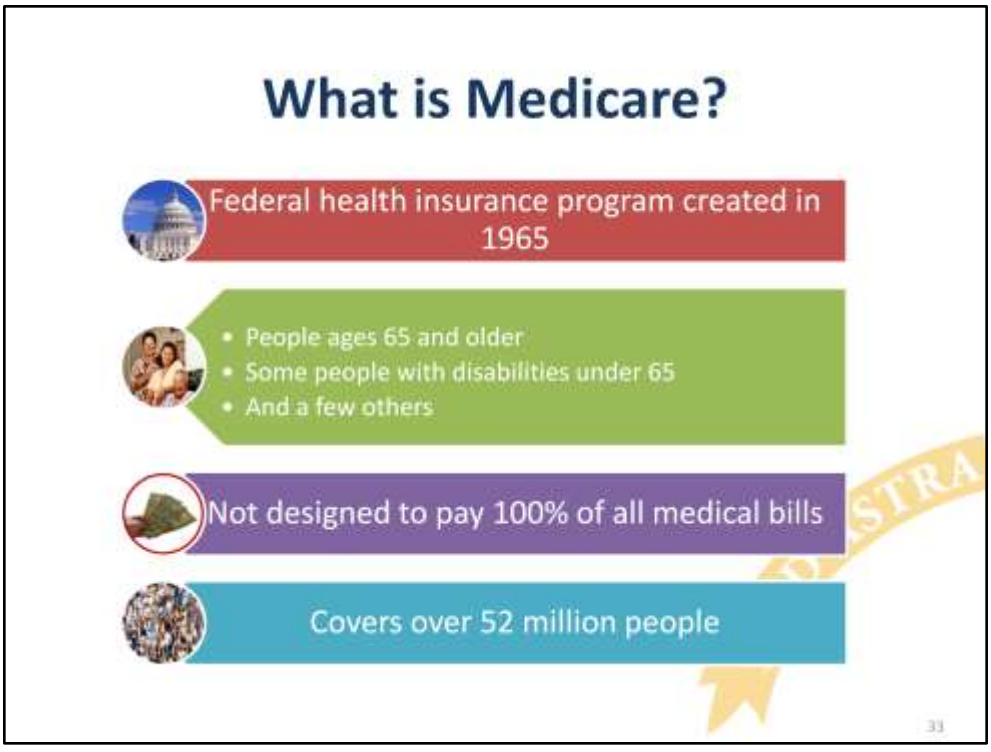
Also, there may be legal consequences for beneficiaries who are complicit in fraud and abuse, since participating in schemes to defraud Medicare is illegal!



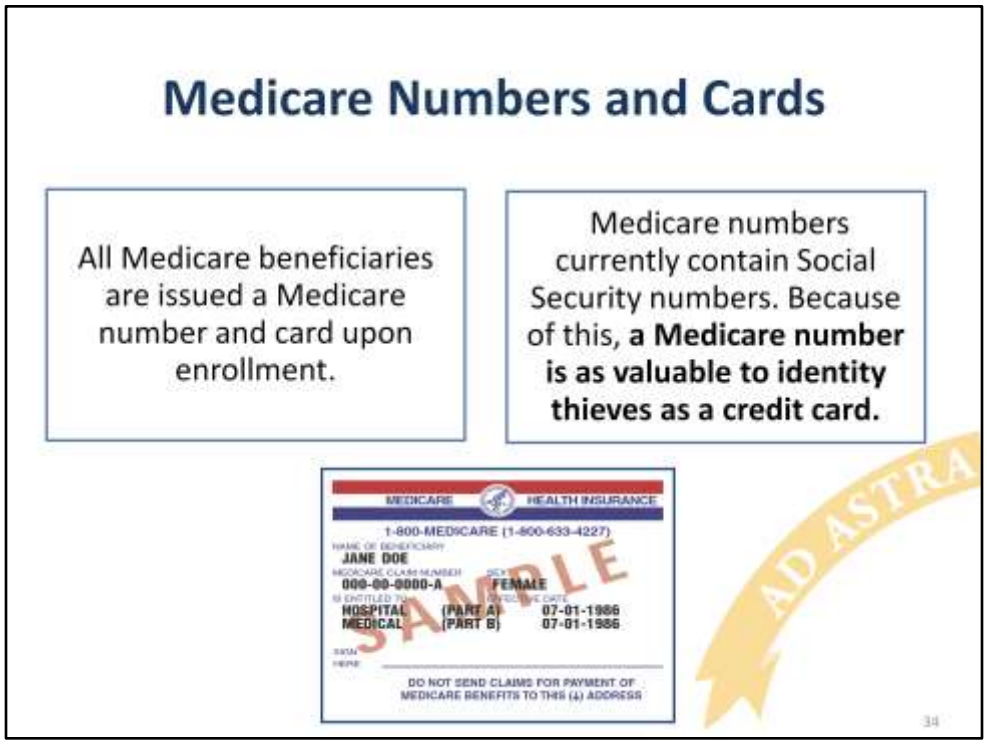
The Senior Medicare Patrol is here to help you avoid these problems.

Senior Medicare Patrol programs, or SMPs, help Medicare and Medicaid beneficiaries protect, detect, and report health care fraud. By doing so, we help preserve the integrity of the Medicare and Medicaid programs. Because this work often requires face-to-face contact to be most effective, SMPs nationwide rely on approximately 5,000 volunteers who are active each year to help in this effort.

Education and prevention are at the core of the Senior Medicare Patrol program, as demonstrated by its mission:
to empower and assist Medicare beneficiaries, their families, and caregivers to protect, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.

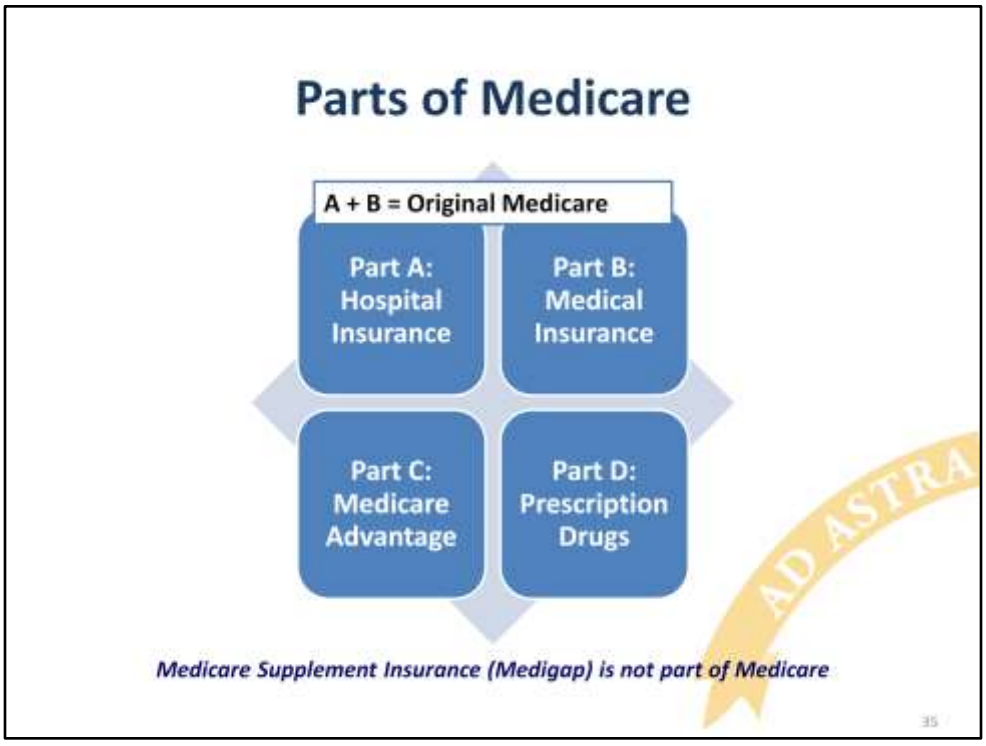


What is Medicare?
Medicare is the federal health insurance program created in 1965 for people ages 65 and older, some people with disabilities under 65, and a few others, such as those with End-Stage Renal Disease (ESRD) and certain people with ALS (Lou Gehrig's disease or amyotrophic lateral sclerosis). The Medicare program was NOT designed to pay 100 percent of all medical bills. In 2013, according to the Medicare Trustees report, Medicare covered over 52 million people: 43.5 million people age 65 and older and 8.8 million people with disabilities.



Medicare beneficiaries are issued a Medicare number upon enrollment. Everyone enrolled in Medicare is also issued a Medicare card. It is then used like any other insurance card.

In most cases, Medicare numbers contain the beneficiary's Social Security number, making the Medicare number as valuable to identity thieves as a credit card.



Medicare consists of four parts called Part A, Part B, Part C, and Part D. Medicare Part A and Part B together are known as "Original Medicare." Beneficiaries in Original Medicare have the option of purchasing supplemental insurance to cover gaps in coverage. However, Medicare supplement insurance (also known as Medigap) is not part of Medicare.

Medicare Part C offers an alternate system for delivering the same services as Original Medicare through private insurance plans, called Medicare Advantage Plans.

Lastly, Medicare Part D insurance delivers prescription drug coverage through certain Medicare Advantage Plans or through standalone Medicare Prescription Drug Plans.

Medicare Part A is also referred to as Hospital Insurance.

Part A provides health care benefits that help cover the following services:

- ✓ Inpatient hospital care
- ✓ Inpatient skilled nursing facility (SNF) care
- ✓ Home health care
- ✓ Hospice care

Medicare Part B is also referred to as Medical Insurance.

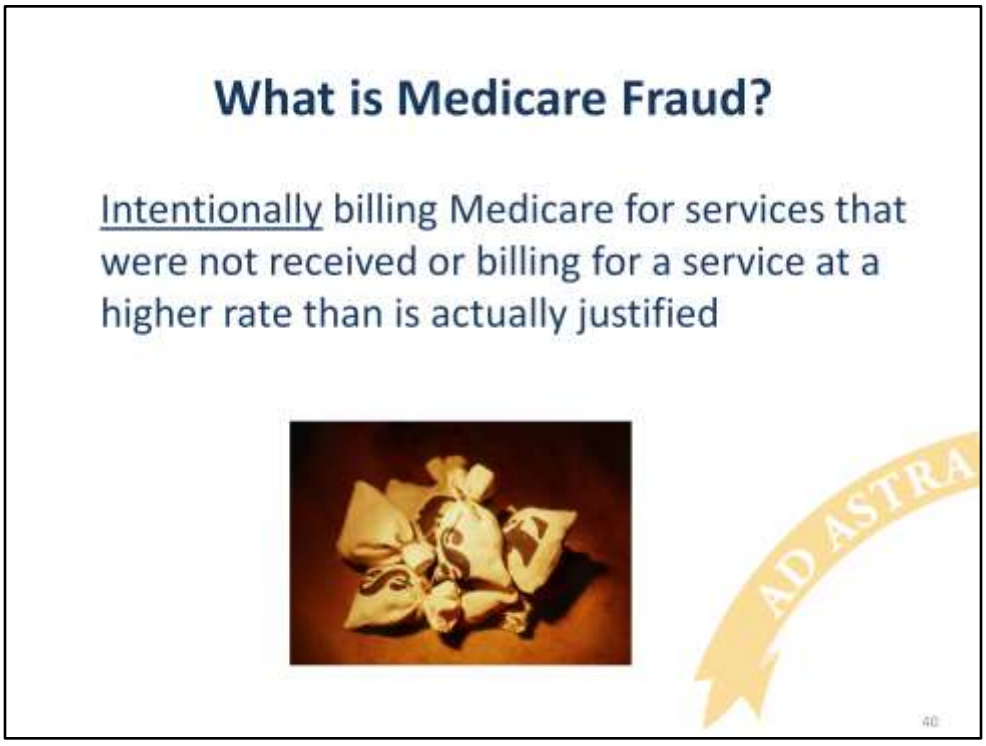
Part B provides health care benefits that help cover the following services:

- ✓ Doctor services
- ✓ Durable medical equipment (DME)
- ✓ Home health care
- ✓ X-rays, lab services
- ✓ Outpatient hospital services
- ✓ Mental health services
- ✓ Most preventive health care services (“Welcome to Medicare” or yearly “Wellness” visits)

Medicare Part C, more commonly called Medicare Advantage, is an alternative to Original Medicare when elected by a Medicare beneficiary. Medicare Advantage Plans are offered by private insurance companies that sign a contract with Medicare. Medicare Advantage Plans must provide all Medicare Part A and Part B benefits to plan members. Many offer benefits that Original Medicare doesn't cover, such as routine hearing, vision, and dental care and nonambulance medical transportation services. Most Medicare Advantage Plans also include Medicare Part D prescription drug coverage. Beneficiaries are encouraged to compare plans prior to enrolling because coverage varies. A plan comparison tool is available on Medicare's website: www.Medicare.gov.

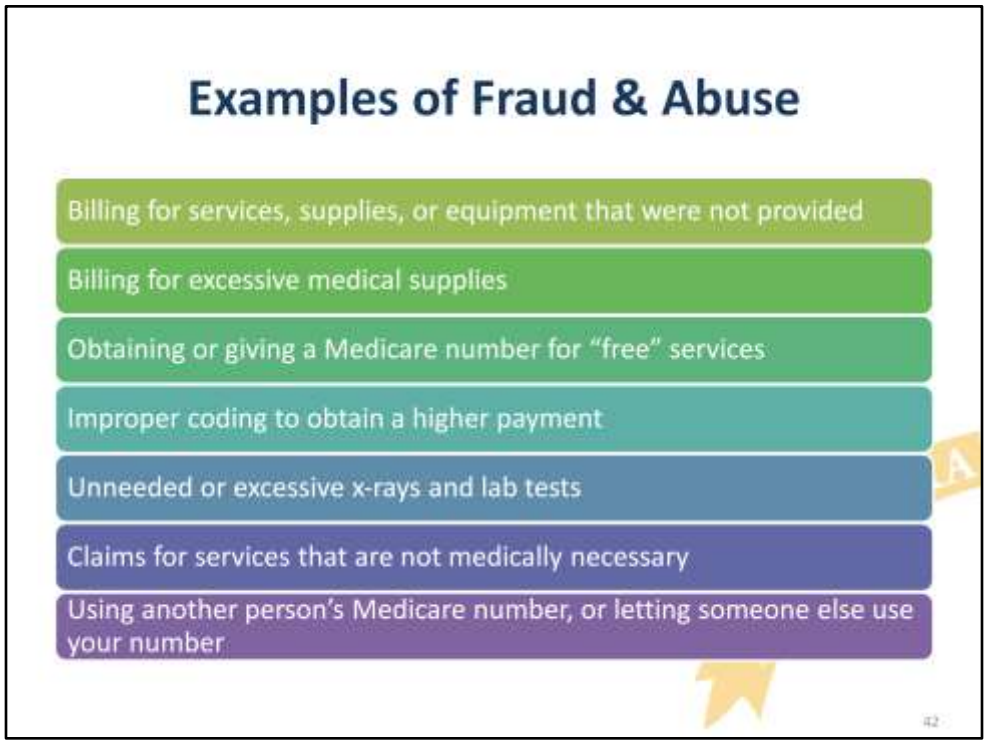
Medicare Part D is also referred to as Medicare Prescription Drug Coverage. The Centers for Medicare & Medicaid Services (CMS) contracts with private companies to offer Medicare Prescription Drug Plans to people with Medicare.

Beneficiaries are encouraged to compare plans prior to enrolling because coverage varies. The drugs covered, copayment amounts, deductibles, and coverage in the gap or "donut hole" differ from plan to plan. A plan comparison tool is available on the Medicare website: www.Medicare.gov.



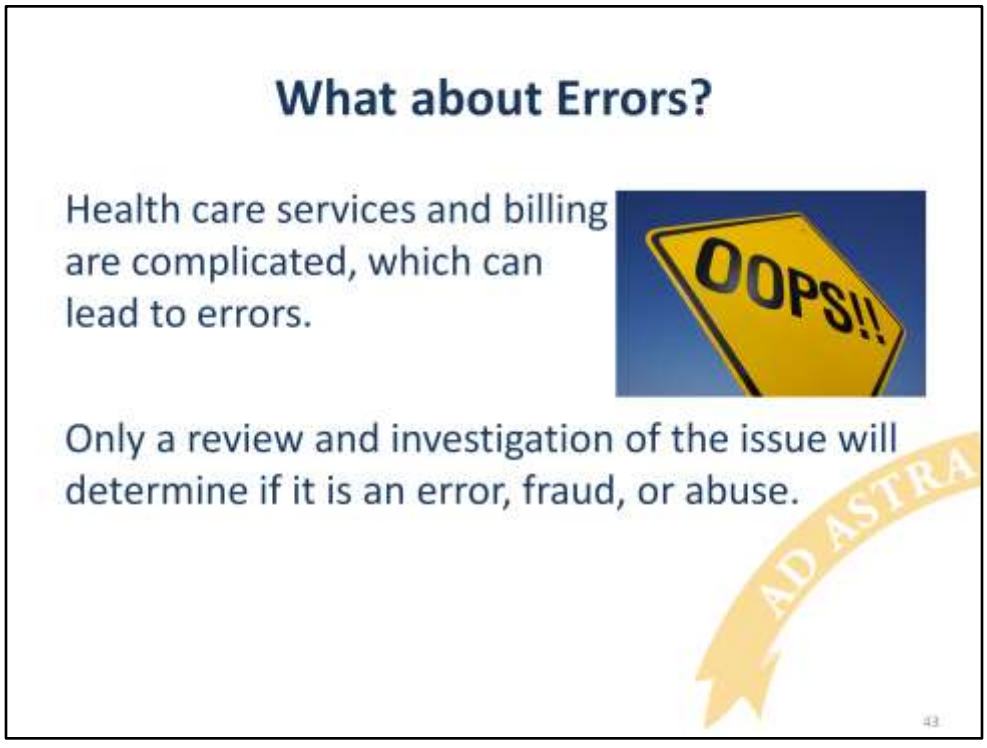
Now that we've learned a little bit about Medicare, let's look at Medicare fraud. Medicare fraud involves intentionally billing Medicare for services that were not received, or billing for a service at a higher rate than is actually justified.

Next, what is Medicare abuse?
Medicare abuse occurs when providers supply services or products that are not medically necessary or that do not meet professional standards. Medicare fraud and abuse are very similar and many times overlap.



Here are some examples of fraud and abuse:

- Billing for services, supplies, or equipment that were not provided
- Billing for excessive medical supplies
- Obtaining or giving Medicare number for "free" services; treat any offer of free services in exchange for your Medicare or health care identification number with caution
- Improper coding to obtain a higher payment
- Unneeded or excessive x-rays and lab tests
- Claims for services that are not medically necessary
- Using another person's Medicare number, or letting someone else use your number, to obtain medical care, supplies, or equipment



In addition to fraud and abuse, it's also important to consider errors. Providing and billing for health care services involves many of complicated steps, which may lead to errors. Most Medicare payment errors are simply mistakes and are not the result of physicians, providers, or suppliers trying to take advantage of the Medicare system.

Sometimes what may seem like a simple error can turn out to be fraud or abuse, and what might appear to be fraud or abuse can be a simple error. Only a review and investigation of the issue will determine whether it is an error, fraud, or abuse.

So, what can YOU do to take charge and help prevent Medicare fraud, errors, and abuse? There are three easy steps: protect, detect, and report.

First, protect yourself and your loved ones from Medicare fraud and abuse!

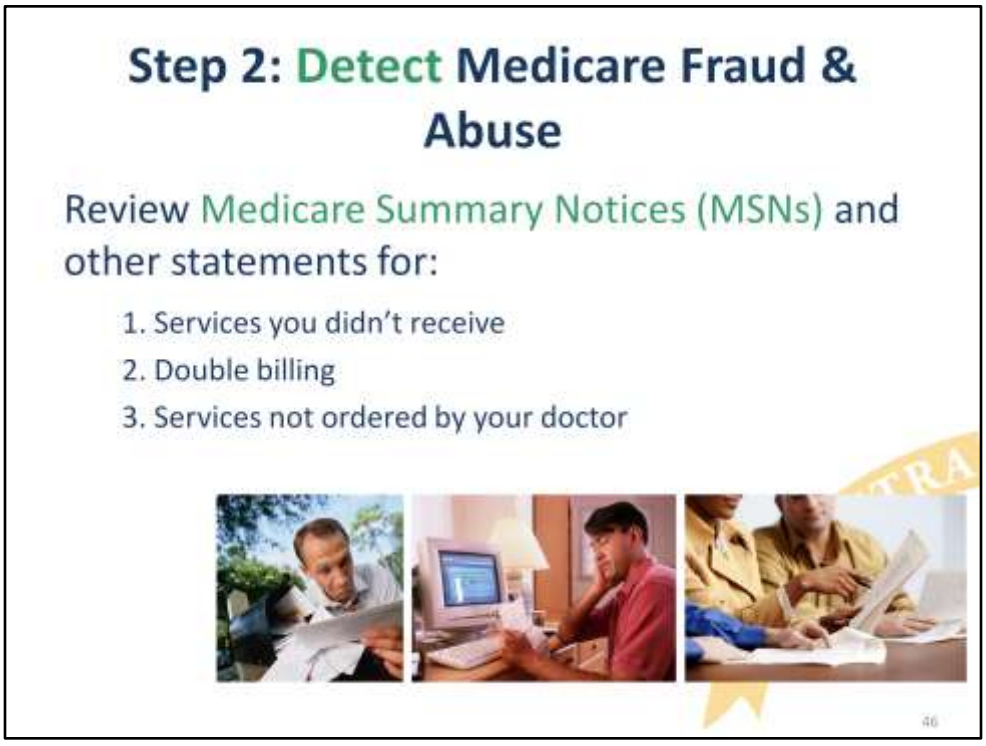
•Do treat your Medicare and Social Security cards and numbers like your credit card. Don't give out your Medicare number except to your doctor or other Medicare provider. Don't carry your Medicare card unless you will need it. Only take it to doctors' appointments, visits to your hospital or clinic, or trips to the pharmacy.

•Do watch out for identity theft. Scam artists will not only use your Medicare number to defraud the Medicare system, but this is also one way that people can steal your identity, since your Social Security number is typically included in your Medicare number!

•Do be aware that Medicare doesn't call or visit to sell you anything. However, Medicare does now require their contractors to contact beneficiaries from time to time, so make sure to be vigilant. Keep in mind that you don't have to talk to anyone who calls you or shows up at your door who you do not trust…Medicare contractors will understand.

•Do be cautious of offers for "free" medical services. If it sounds too good to be true, it probably is!

•Do pass it on! Share this information with friends and family members who might not already know how to prevent Medicare fraud and abuse.



Second, detect Medicare fraud and abuse:
Even when you do everything right, there is a chance that you could be a target of health care fraud. There are many ways that your personal information can be used without your permission.

•Always review your Medicare Summary Notice and Explanation of Benefits for mistakes.

•Look for three things on your billing statements:

1. Charges for something you didn't receive
2. Billing for the same thing twice, and
3. Services that were not ordered by your doctor

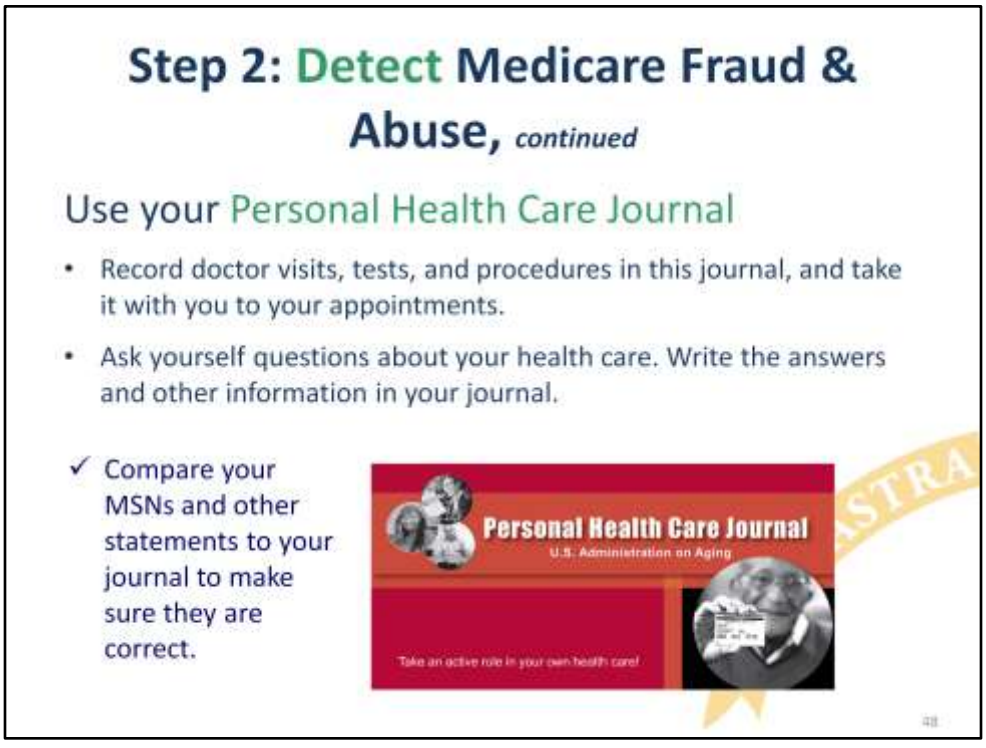
Suggested Handout: MSN Fact Sheet *(available in multiple languages)*
www.smpresource.org > Resources for SMPs > SMP Resource Library
Tip: If you have time, hand out the MSN Fact Sheet and review it with the group. Explain how to use your MSN to detect fraud, errors, and abuse, and review the information to look for in each type of statement.

Medicare Summary Notices are typically sent on a quarterly basis. To better detect potential issues, you can access your Medicare information online! www.MyMedicare.gov is a helpful tool for beneficiaries to view their most recent MSNs, track claims made on their behalf, and check payment status. Once you register, access to your current Medicare account is available 24 hours a day.

At MyMedicare.gov, you can also:

- Check Part B deductible status
- View eligibility information
- Track available preventive services
- Find Medicare health or prescription drug plans
- Access Part D plan claims information

MyMedicare.gov has the potential to serve as a valuable, real-time tool in combating fraud and abuse. If you have Medicare and access to a computer, this might be a good option for you.



Another way to help detect fraud, errors, and abuse is by using a Personal Health Care Journal.

•Record doctor visits, tests, and procedures in your personal health care journal and/or calendar, and take your journal with you to all of your appointments.

•Directions for using the Personal Health Care Journal are provided in the front of the journal and include a short list of questions you may want to ask yourself before your health care appointment. For example:

- •Is this appointment going to be covered by Medicare or my other insurance?
- •What are my symptoms? When did they start? What makes them better or worse?
- •What over-the-counter or prescription medications am I taking?

•Write down the answer to these questions, as well as what happens during your visit, in your journal.

•Later, compare your Medicare Summary Notices and other statements to your personal health care journal and prescription drug receipts to make sure they are correct.

Third, if you detect or suspect fraud or abuse, report it. You will protect other people from becoming victims and help to save your Medicare benefits. Here are the steps you should take to report your concerns:

•First, if you have questions about information on your Medicare Summary Notice (known as your MSN) or Explanation of Benefits (called an EOB), call your provider or plan to find out if it was an error that they can correct without taking any further action.

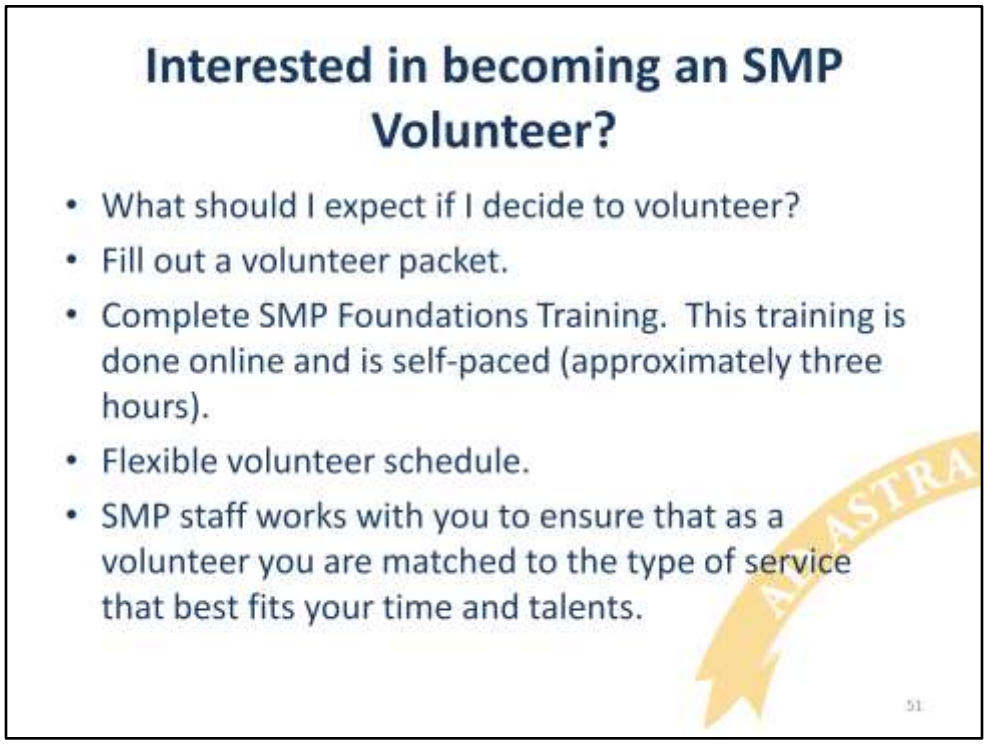
•If you are not satisfied with the response you get or are not comfortable calling your provider or plan, gather all of the facts that you can about your situation.

•Make sure you have your MSN or EOB and any other supporting documentation that shows the possible fraud or abuse.

•Then, contact your SMP if you need help.

•Please keep in mind that services provided by your SMP are free and confidential.

Now that you have learned how to protect, detect, and report Medicare fraud, errors, and abuse, would you like to help other Medicare beneficiaries do so too? SMP volunteers, like ME, give group presentations like this one, provide one-on-one counseling to beneficiaries, perform administrative work, and more! If you would like to join the SMP program as a volunteer, please contact the local SMP.



What should I expect if I decide to volunteer?
Fill out a volunteer packet.
Complete SMP Foundations Training. This training is done online and is self-paced (approximately three hours).
Flexible volunteer schedule.
SMP staff works with you to ensure that as a volunteer you are matched to the type of service that best fits your time and talents.

If you need to reach us at the Kansas SMP, please visit us online or call us. Our contact information is provided on the screen and/or in the handouts.

Kansas Senior Medicare Patrol (SMP)

Protect, Detect, and Report potential Medicare fraud and abuse

April Hazen, Senior Medicare Patrol Program Director

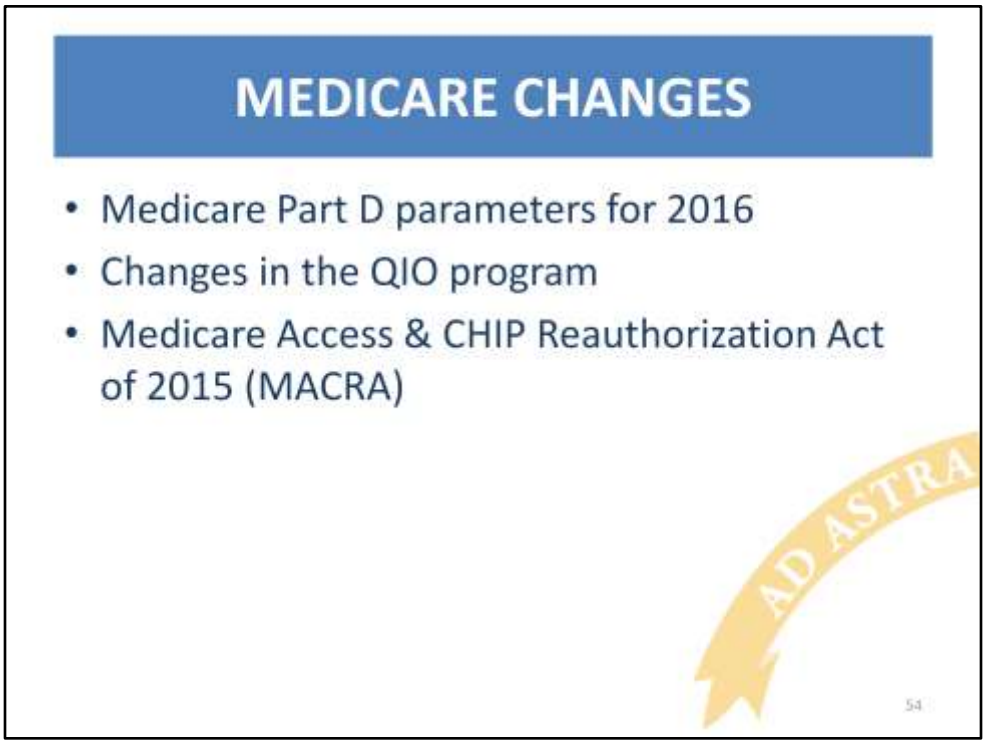
april.hazen@kdads.ks.gov

785-296-8450

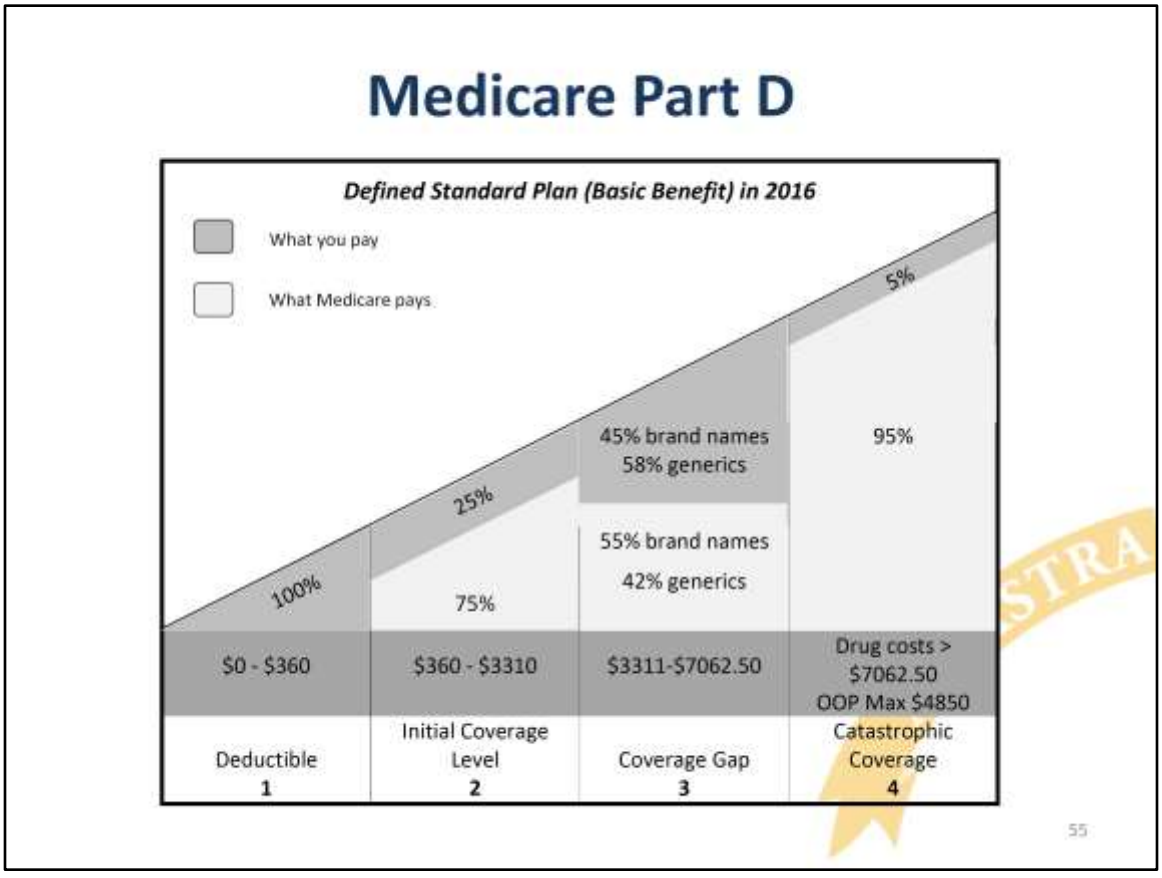
Tanya Lorenzo, Senior Medicare Patrol Program Manager

tanya.lorenzo@kdads.ks.gov

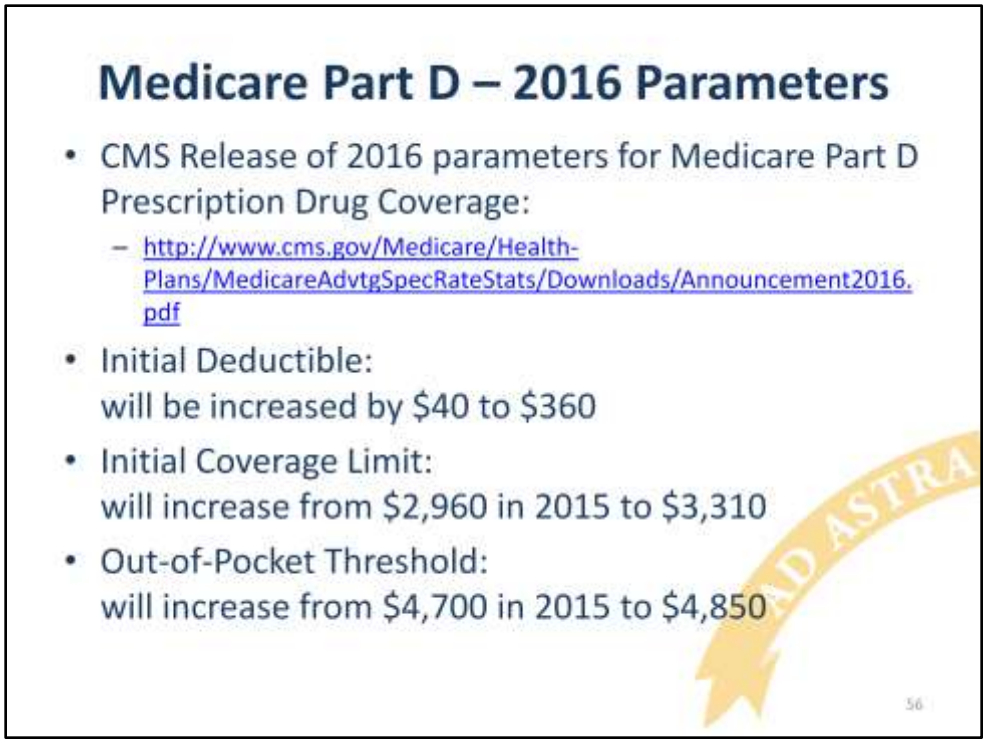
785-296-0377



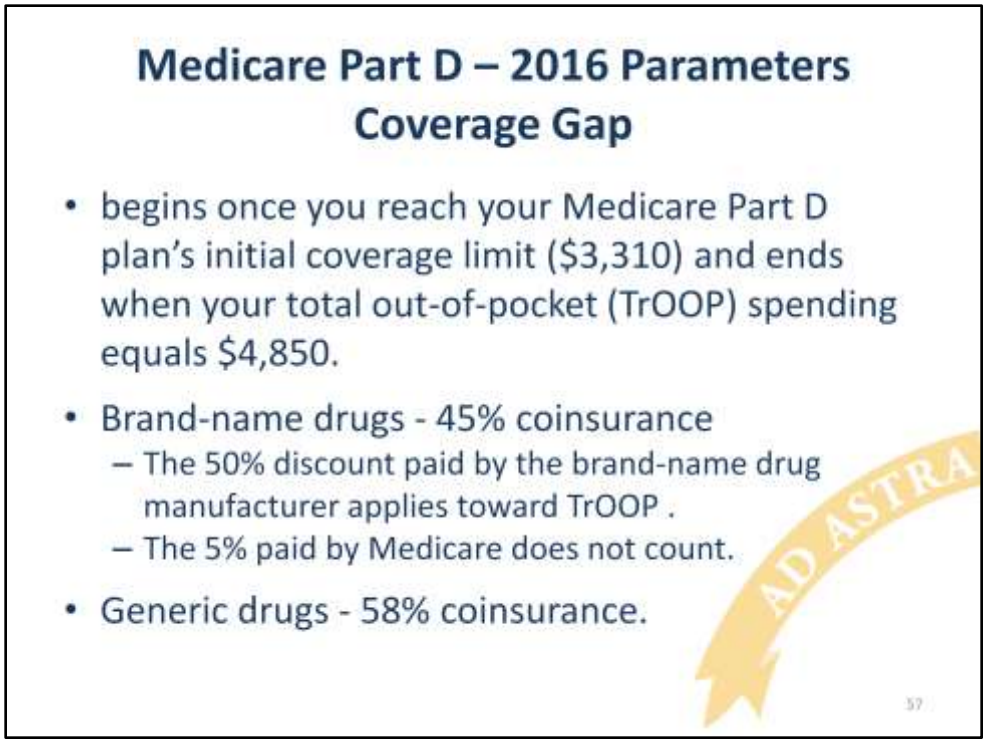
Medicare Part D parameters for 2016
Changes in the QIO program
Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)



2016 Defined Standard Plan (Basic Benefit)



CMS Release of 2016 parameters for Medicare Part D Prescription Drug Coverage:
http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf
Initial Deductible:
will be increased by $40 to $360
Initial Coverage Limit:
will increase from $2,960 in 2015 to $3,310
Out-of-Pocket Threshold:
will increase from $4,700 in 2015 to $4,850



Coverage Gap

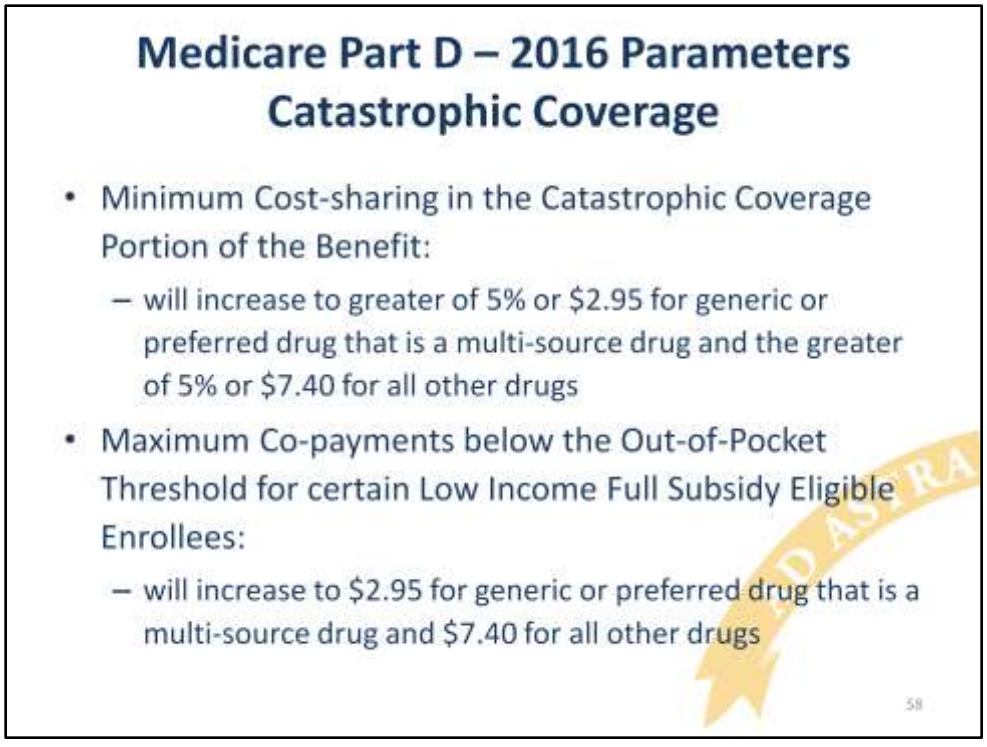
begins once you reach your Medicare Part D plan's initial coverage limit ($3,310) and ends when your total out-of-pocket (TrOOP) spending equals $4,850.

Brand-name drugs - 45% coinsurance

The 50% discount paid by the brand-name drug manufacturer applies toward TrOOP .

The 5% paid by Medicare does not count.

Generic drugs - 58% coinsurance.



Minimum Cost-sharing in the Catastrophic Coverage Portion of the Benefit:

will increase to greater of 5% or $2.95 for generic or preferred drug that is a multi-source drug and the greater of 5% or $7.40 for all other drugs

Maximum Co-payments below the Out-of-Pocket Threshold for certain Low Income Full Subsidy Eligible Enrollees:

will increase to $2.95 for generic or preferred drug that is a multi-source drug and $7.40 for all other drugs

Medicare Part D – 2015-2016 Comparison

Part D Standard Benefit Design Parameters:	2015	2016
Deductible - (after the Deductible is met, Beneficiary pays 25% of covered costs up to total prescription costs meeting the Initial Coverage Limit.	$320	$360
Initial Coverage Limit - Coverage Gap (Donut Hole) begins at this point. (The Beneficiary pays 100% of their prescription costs up to the Out-of-Pocket Threshold)	$2,960	$3,310
Total Covered Part D Drug Out-of-Pocket Spending including the Coverage Gap - Catastrophic Coverage starts after this point.	$6,680.00 + 55% brand discount	$7,062.50 + 55% brand discount
Out-of-Pocket Threshold - This is the Total Out-of-Pocket Costs including the Donut Hole.	$4,700	$4,850
Total Estimated Covered Part D Drug Out-of-Pocket Spending **including the Coverage Gap Discount (NON-LIS)**	$7,061.76	$7,515.22
Catastrophic Coverage Benefit:		
Generic/Preferred Multi-Source Drug	$2.65	$2.95
Other Drugs	$6.60	$7.40

59

Medicare Part D – 2015-2016 Comparison FBDE Parameters

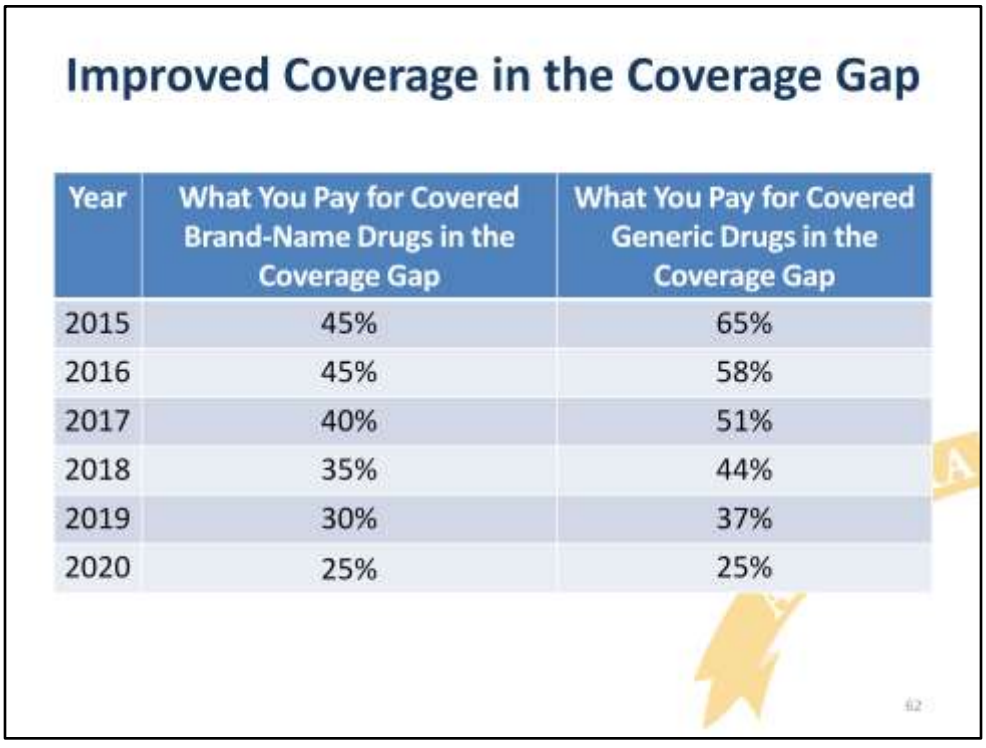
Part D Full Benefit Dual Eligible (FBDE) Parameters:	2015	2016
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL:		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.20	$1.20
Other	$3.60	$3.60
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL:		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.65	$2.95
Other	$6.60	$7.40
Above Out-of-Pocket Threshold	$0.00	$0.00

60

Medicare Part D – 2015-2016 Comparison Non-FBDE & Partial Parameters

Part D Full Subsidy - Non Full Benefit Dual Eligible Full Subsidy Parameters:	2015	2016
Deductible	$0.00	$0.00
Generic/Preferred Multi-Source Drug	$2.65	$2.95
Other	$6.60	$7.40
Maximum Copay above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy Parameters:	**2015**	**2016**
Deductible	$66.00	$74.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.65	$2.95
Other	$6.60	$7.40

61



What You Pay for Covered Brand-Name Drugs in the Coverage Gap
What You Pay for Covered Generic Drugs in the Coverage Gap

In August 2014, the Quality Improvement Organization (QIO) program structure changed

There are now two QIOs contracted in each state

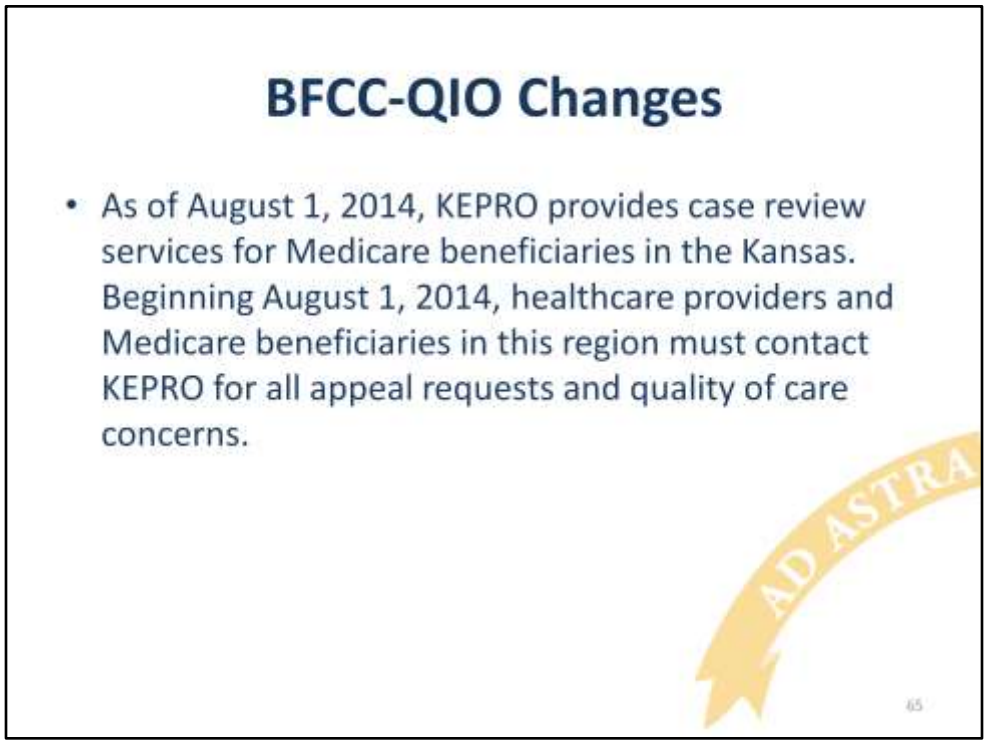
- Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
    - KEPRO
- Quality Innovation Network Quality Improvement Organization (QIN-QIO)
    - Great Plains Innovation Network

BFCC-QIOs manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families.

The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Kansas is KEPRO.

855-408-8557

https://www.keproqio.com/

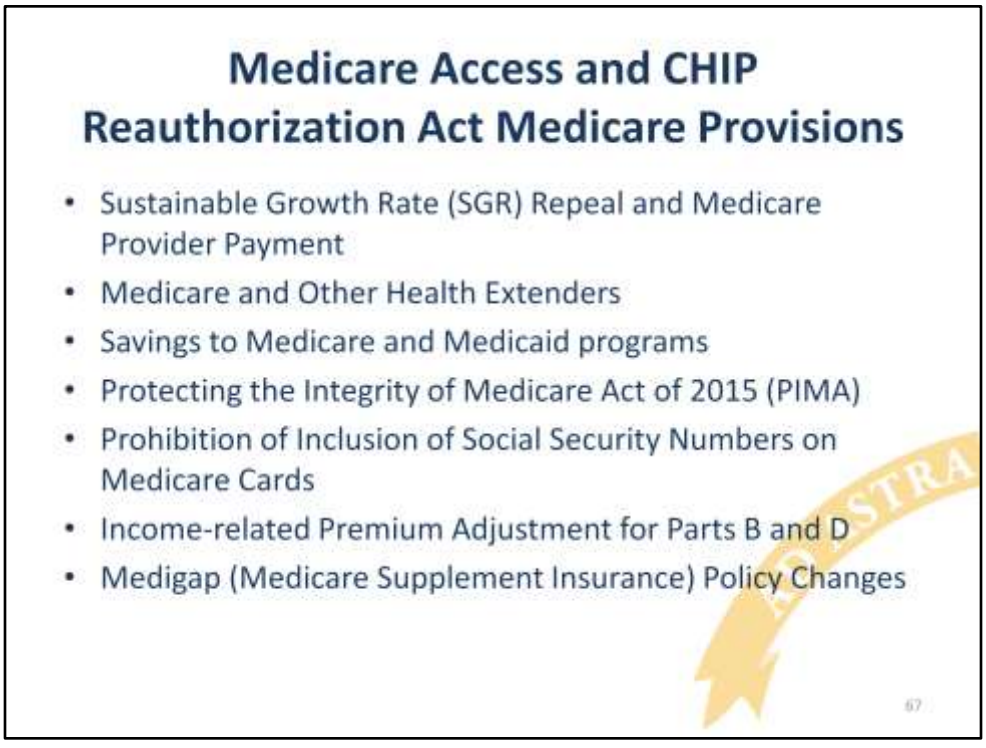


As of August 1, 2014, KEPRO provides case review services for Medicare beneficiaries in the Kansas. Beginning August 1, 2014, healthcare providers and Medicare beneficiaries in this region must contact KEPRO for all appeal requests and quality of care concerns.

For one year, from August 1 2014 through July 31, 2015, the toll-free phone numbers for the former QIOs were automatically forwarded to KEPRO. This ended August 1, 2015. All Medicare beneficiaries should be referred directly to KEPRO at their toll-free phone number, 855-408-8557.

QIN-QIOs are responsible for working with providers and communities on data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care and transparency at local, regional, and national levels.
The QIN Quality Improvement Organization (QIN-QIO) for Kansas is Great Plains Quality Innovation Network.

The former QIO for Kansas, KFMC, is part of this network
Phone: 402-476-1700
http://greatplainsqin.org/



Sustainable Growth Rate (SGR) Repeal and Medicare Provider Payment
Medicare and Other Health Extenders
Savings to Medicare and Medicaid programs
Protecting the Integrity of Medicare Act of 2015 (PIMA)
Prohibition of Inclusion of Social Security Numbers on Medicare Cards
Income-related Premium Adjustment for Parts B and D
Medigap (Medicare Supplement Insurance) Policy Changes

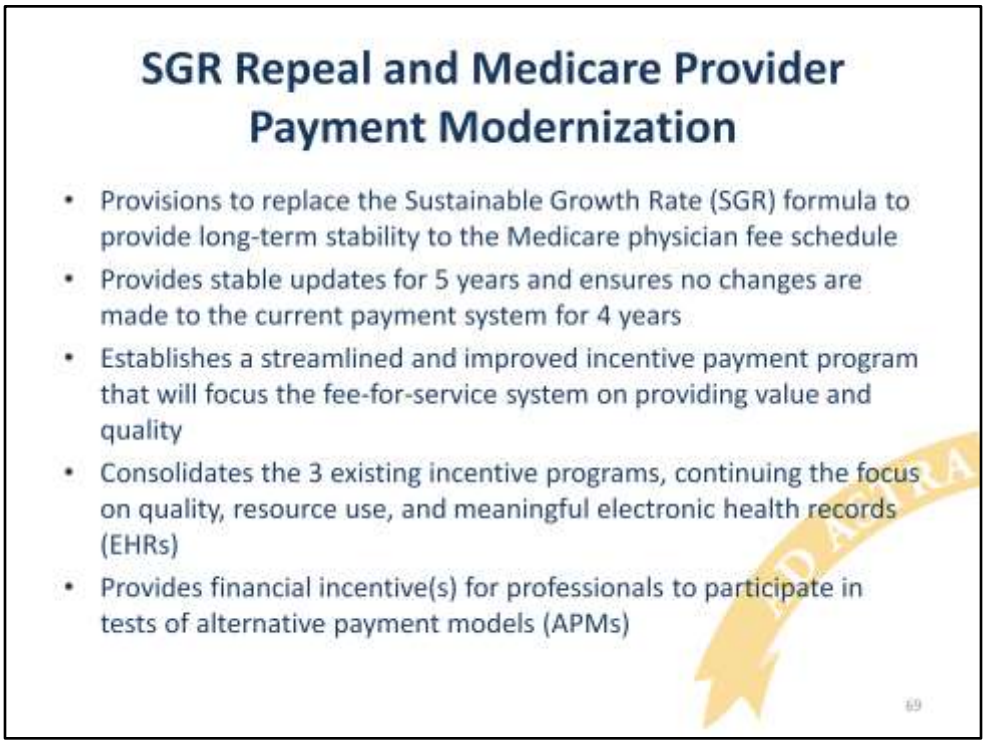
As part of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 bill signed in April 2015, Social Security Numbers will be removed from Medicare Cards

Congress provided $320 million over four years to pay for the change.
H.R.2 - Medicare Access and CHIP Reauthorization Act of 2015
04/16/2015 Became Public Law No: 114-10.

Medicare officials have up to four years to start issuing cards with new identifiers.

They will have four more years to reissue cards held by current beneficiaries.
The new Medicare Beneficiary Identifier (MBI) will be

Recognizably different than the Medicare Health Insurance Claim Number (HICN)
The same length as the HICN
Displayed on the Medicare cards
Will be used by external partners (Beneficiary, Provider, Plans, etc.) participating in claims processing and other related activities when interacting with CMS



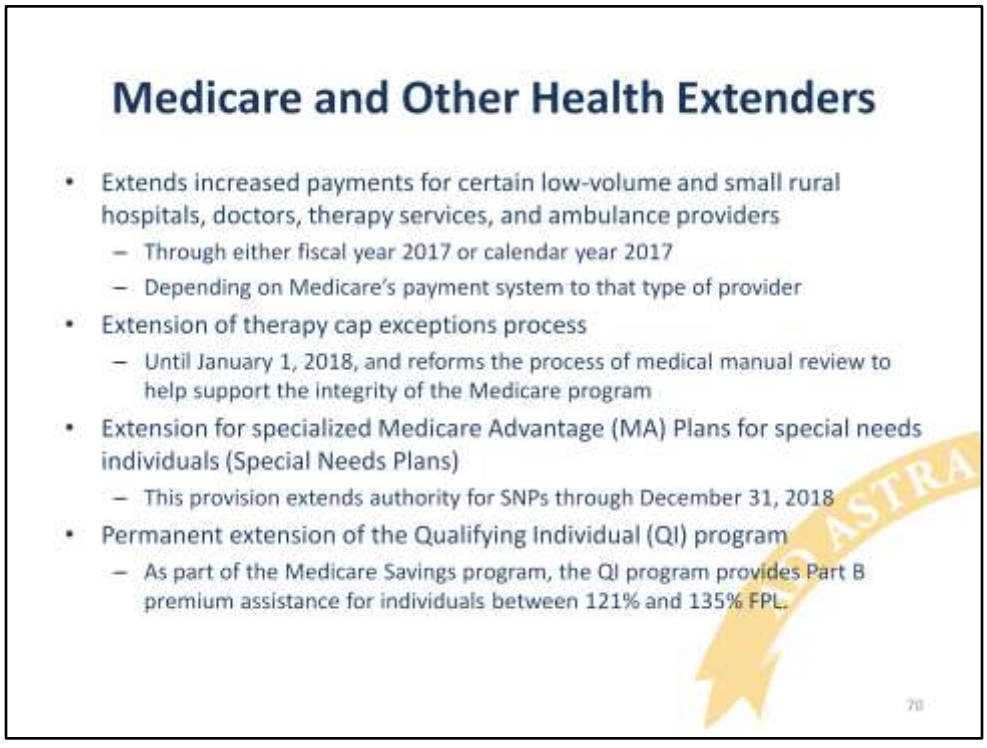
Provisions to replace the Sustainable Growth Rate (SGR) formula to provide long-term stability to the Medicare physician fee schedule

Provides stable updates for 5 years and ensures no changes are made to the current payment system for 4 years

Establishes a streamlined and improved incentive payment program that will focus the fee-for-service system on providing value and quality

Consolidates the 3 existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health records (EHRs)

Provides financial incentive(s) for professionals to participate in tests of alternative payment models (APMs)



Extends increased payments for certain low-volume and small rural hospitals, doctors, therapy services, and ambulance providers

Through either fiscal year 2017 or calendar year 2017

Depending on Medicare's payment system to that type of provider

Extension of therapy cap exceptions process

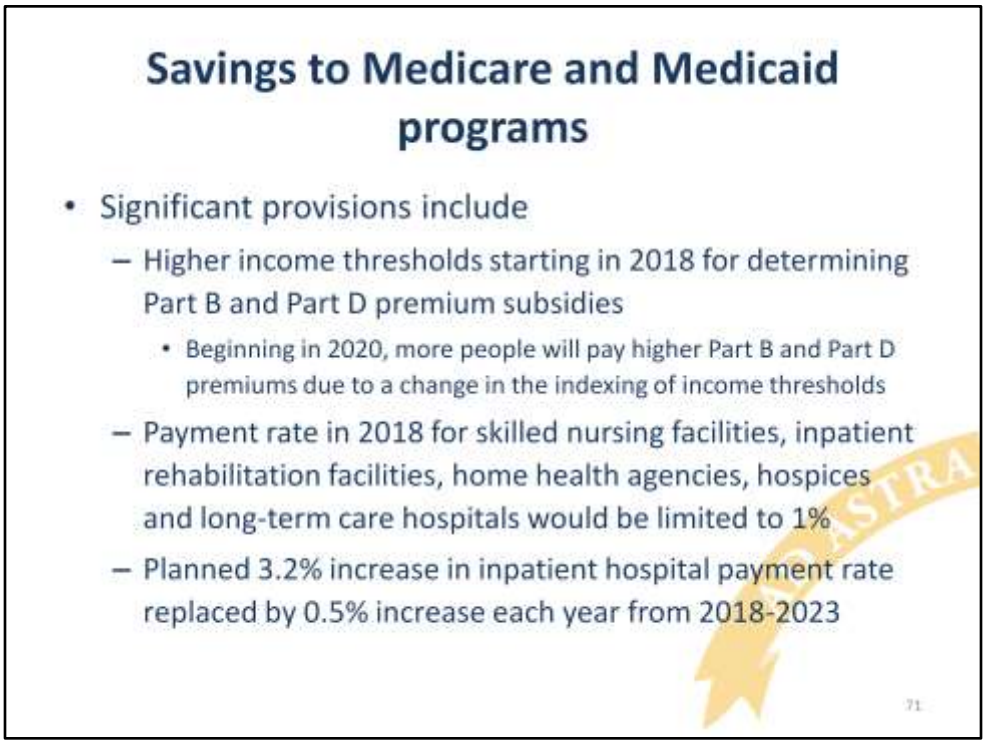
Until January 1, 2018, and reforms the process of medical manual review to help support the integrity of the Medicare program

Extension for specialized Medicare Advantage (MA) Plans for special needs individuals (Special Needs Plans)

This provision extends authority for SNPs through December 31, 2018

Permanent extension of the Qualifying Individual (QI) program

As part of the Medicare Savings program, the QI program provides Part B premium assistance for individuals between 121% and 135% FPL.



Significant provisions include

Higher income thresholds starting in 2018 for determining Part B and Part D premium subsidies

Beginning in 2020, more people will pay higher Part B and Part D premiums due to a change in the indexing of income thresholds

Payment rate in 2018 for skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospices and long-term care hospitals would be limited to 1%

Planned 3.2% increase in inpatient hospital payment rate replaced by 0.5% increase each year from 2018-2023

Income-related Premium Adjustment for Parts B and D

Modified Adjusted Gross Income Threshold for Years Prior to 2018	Modified Adjusted Gross Income Threshold for Years Beginning in 2018	Applicable Percentage
More than $85,000 but not more than $107,000	More than $85,000 but not more than $107,000	35%
More than $107,000 but not more than $160,000	More than $107,000 but not more than $133,500	50%
More than $160,000 but not more than $214,000	More than $133,500 but not more than $160,000	65%
More than $214,000	More than $160,000	80%

Beginning in 2020, the income thresholds would be adjusted each year by increasing the previous year's income threshold amounts by the consumer price index for urban consumers.

72

Strengthening Medicare's ability to fight fraud and build on existing program integrity policies

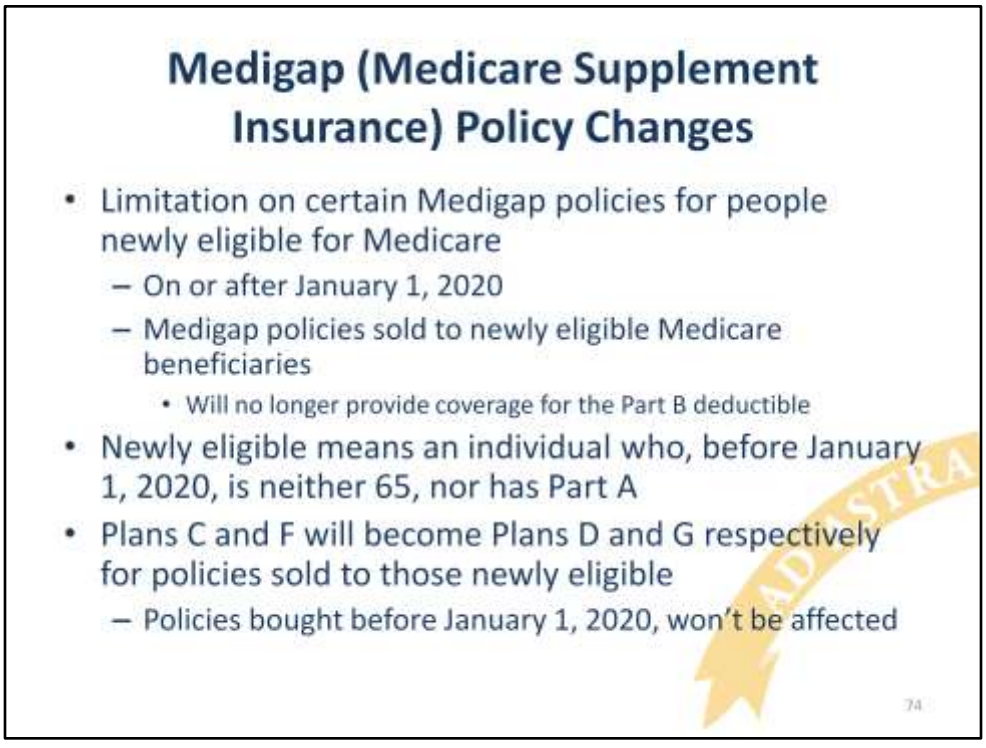
Prohibiting Social Security numbers on Medicare cards (no later than 4 years after enactment)

Preventing payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals

Modifying Medicare Durable Medical Equipment Face-to-Face Encounter Documentation Requirement

Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims (starting plan year 2016)

Option to Receive Medicare Summary Notice Electronically (starting in Fall of 2017)



Limitation on certain Medigap policies for people newly eligible for Medicare

On or after January 1, 2020

Medigap policies sold to newly eligible Medicare beneficiaries

Will no longer provide coverage for the Part B deductible

Newly eligible means an individual who, before January 1, 2020, is neither 65, nor has Part A

Plans C and F will become Plans D and G respectively for policies sold to those newly eligible

Policies bought before January 1, 2020, won't be affected

Administered by Humana

Designed to remove gaps in coverage for low-income individuals moving to Part D coverage

Gives temporary drug coverage if you have Extra Help and no Medicare drug plan

Coverage may be immediate, current, and/or retroactive

> Medicaid beneficiaries without Part D coverage are automatically enrolled in LI-NET and may have retroactive coverage

Effective June 2014, the Centers for Medicare & Medicaid Services (CMS) requires evidence of Low-Income Subsidy (LIS) or "Extra Help" entitlement prior to point-of-sale facilitated enrollment into Medicare's Limited Income NET Program. This might be their Medicaid card, the letter from SSA or DCF with the notice of award.

Medicare's Limited Income / LI NET Program

Has an open formulary

Doesn't require prior authorization

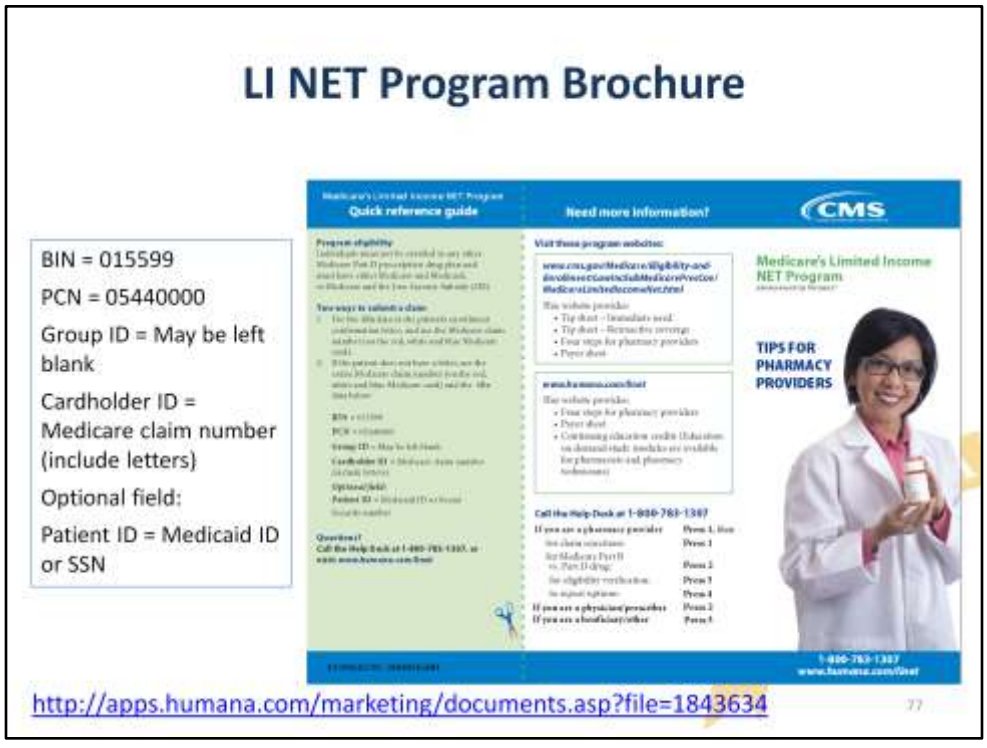
Has no network pharmacy restrictions

Includes standard safety and abuse edits

LI NET SHIP Counselor contact number

1-866-934-2019

https://www.humana.com/provider/pharmacists/pharmacy-services/linet-information



Many pharmacies do not have this information available quickly and will tell beneficiaries who need to use the LI-Net program that they cannot run their prescriptions through with the BIN, PCN, etc. You can give the beneficiary these numbers, as provided in the Humana LI-Net brochure above. You may also want to print the brochure to keep at your desk for easy reference. The link to the brochure is provided below.

BIN = 015599

PCN = 05440000

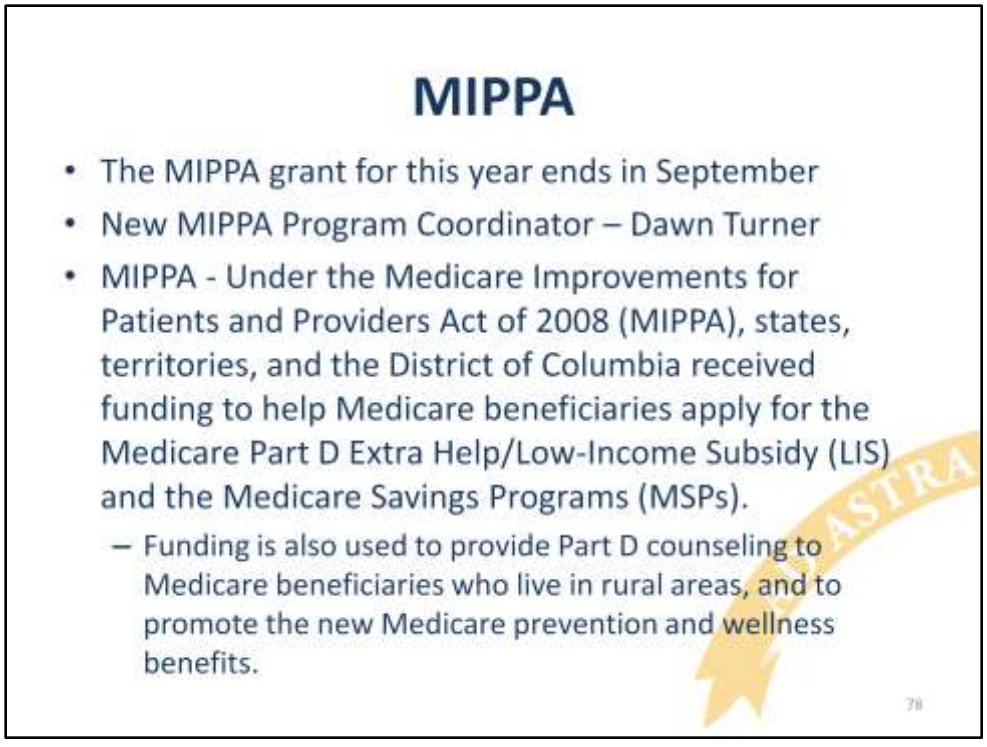
Group ID = May be left blank

Cardholder ID = Medicare claim number (include letters)

Optional field:

Patient ID = Medicaid ID or SSN

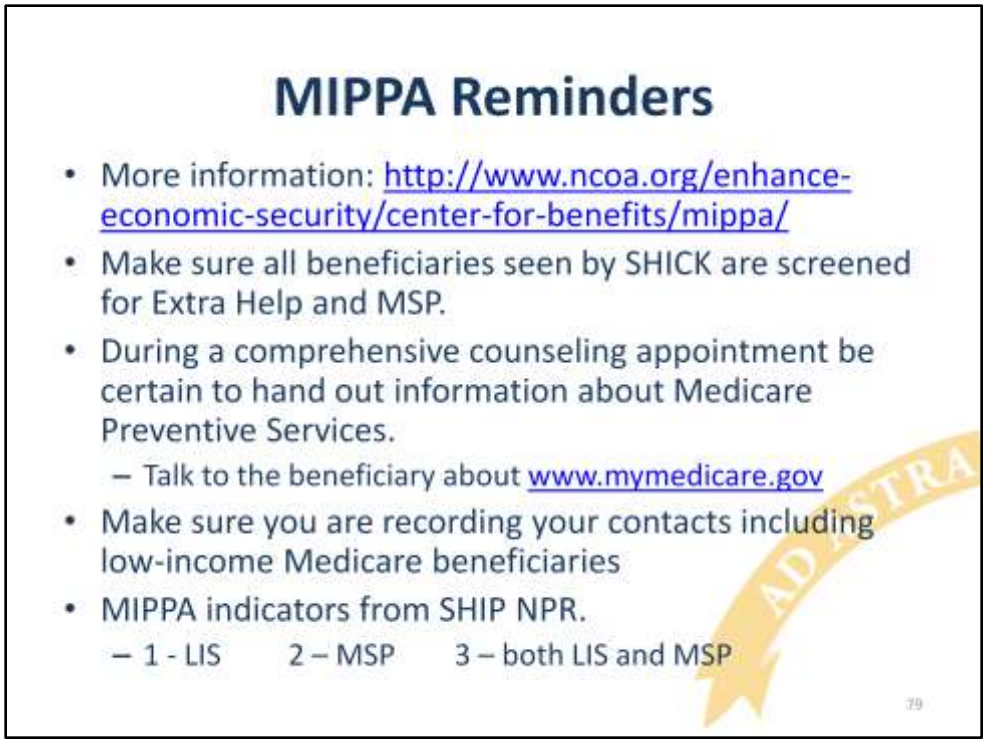
http://apps.humana.com/marketing/documents.asp?file=1843634



New MIPPA Program Coordinator – Dawn Turner

MIPPA - Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), states, territories, and the District of Columbia received funding to help Medicare beneficiaries apply for the Medicare Part D Extra Help/Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSPs).

Funding is also used to provide Part D counseling to Medicare beneficiaries who live in rural areas, and to promote the new Medicare prevention and wellness benefits.



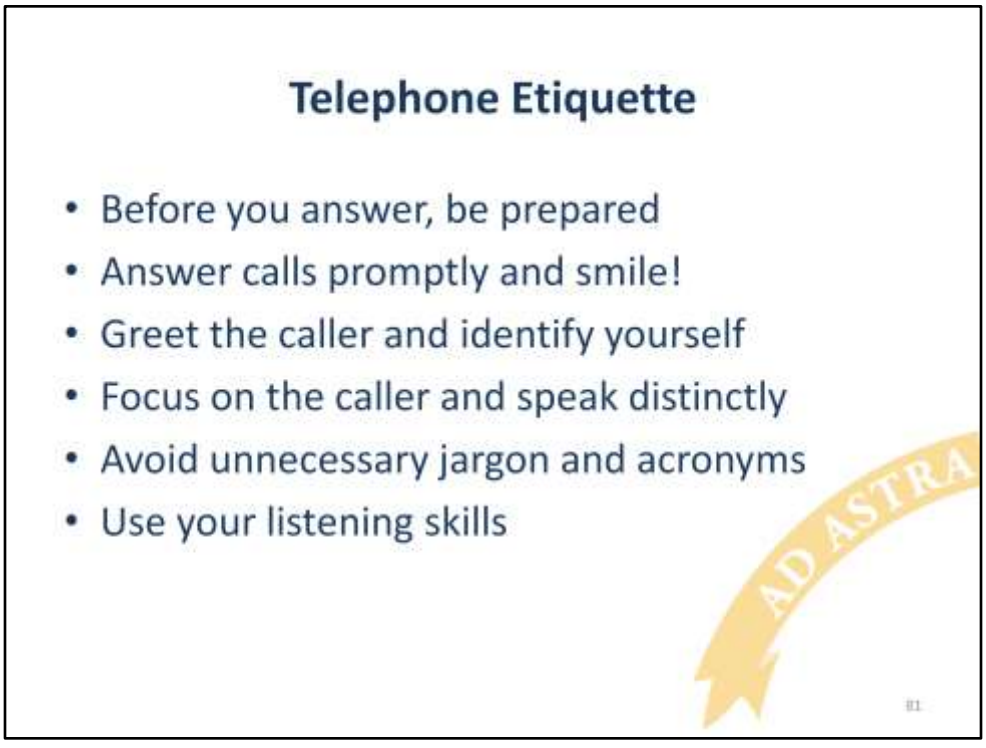
More information: http://www.ncoa.org/enhance-economic-security/center-for-benefits/mippa/
Make sure all beneficiaries seen by SHICK are screened for Extra Help and MSP.
During a comprehensive counseling appointment be certain to hand out information about Medicare Preventive Services.

Talk to the beneficiary about www.mymedicare.gov

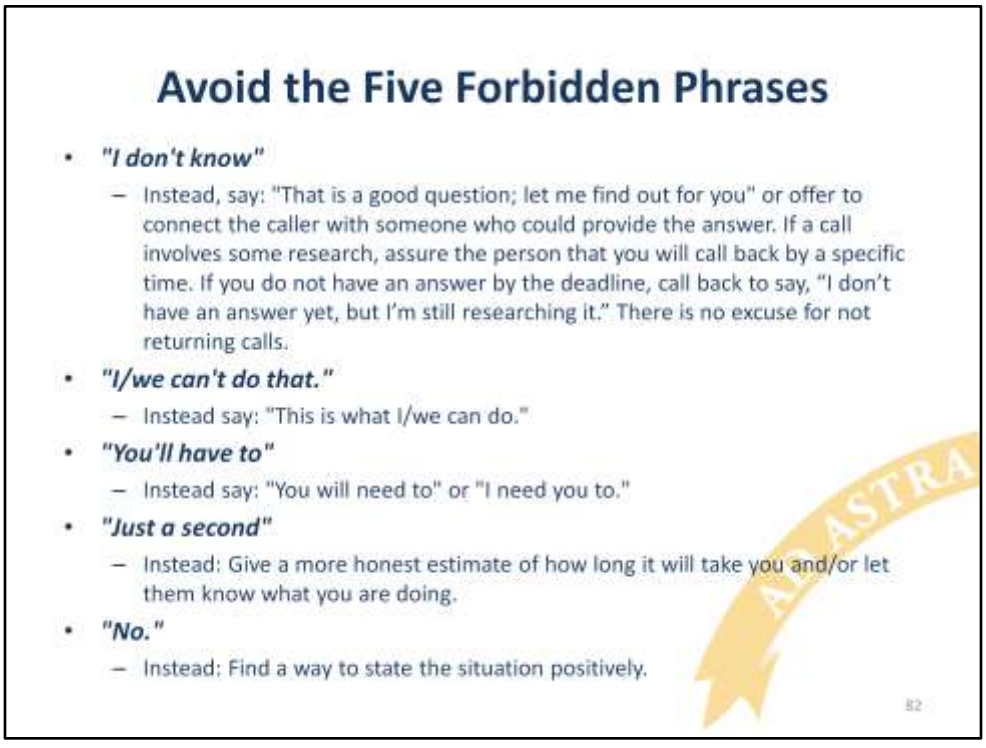
Make sure you are recording your contacts including low-income Medicare beneficiaries
MIPPA indicators from SHIP NPR.

1 - LIS 2 – MSP 3 – both LIS and MSP

Telephone Etiquette
The Four C's – Contact, Clarification, Closure, Completion
Attentive Listening
How to Handle Challenging Callers
Possible Patterns of Difficult Behavior
Helpful Phrases to Remember and Use
Things to Ponder



Before you answer, be prepared
Answer calls promptly and smile!
Greet the caller and identify yourself
Focus on the caller and speak distinctly
Avoid unnecessary jargon and acronyms
Use your listening skills



"I don't know"

Instead, say: "That is a good question; let me find out for you" or offer to connect the caller with someone who could provide the answer. If a call involves some research, assure the person that you will call back by a specific time. If you do not have an answer by the deadline, call back to say, "I don't have an answer yet, but I'm still researching it." There is no excuse for not returning calls.

"I/we can't do that."

Instead say: "This is what I/we can do."

"You'll have to"

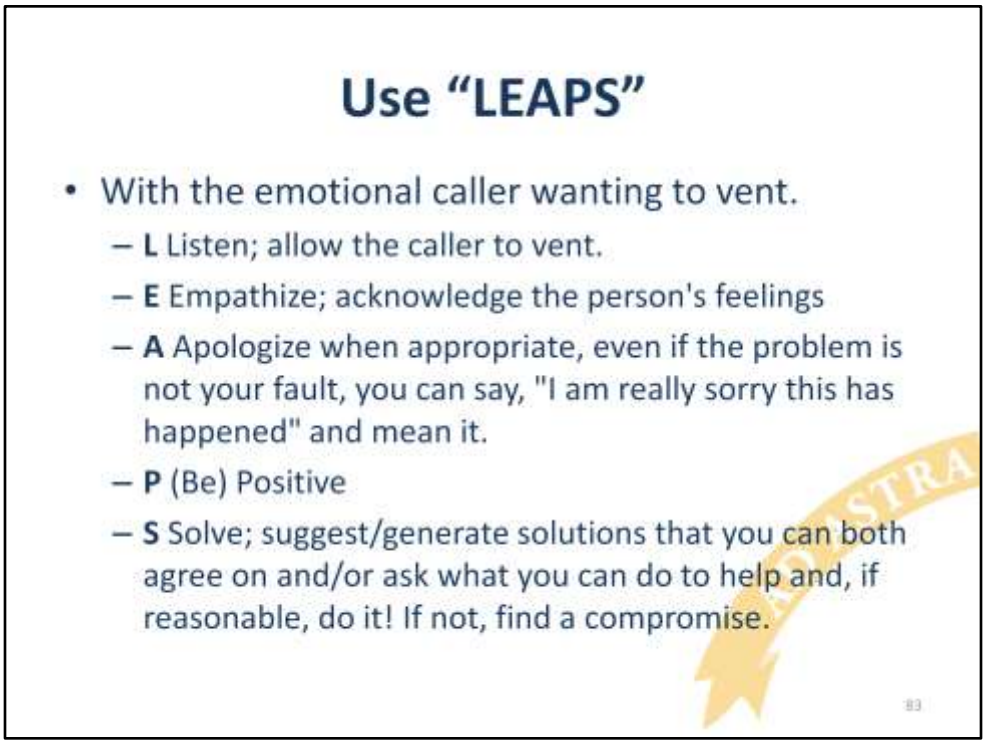
Instead say: "You will need to" or "I need you to."

"Just a second"

Instead: Give a more honest estimate of how long it will take you and/or let them know what you are doing.

"No."

Instead: Find a way to state the situation positively.



With the emotional caller wanting to vent.

L Listen; allow the caller to vent.

E Empathize; acknowledge the person's feelings

A Apologize when appropriate, even if the problem is not your fault, you can say, "I am really sorry this has happened" and mean it.

P (Be) Positive

S Solve; suggest/generate solutions that you can both agree on and/or ask what you can do to help and, if reasonable, do it! If not, find a compromise.

End the conversation with agreement on what is to happen next; if you are to follow-up, explain what you need to do and an estimated timeline.

Thank the caller for calling; invite the caller to call again.

NEVER:

Eat, drink or chew gum while on the phone.

Leave an open line:

ALWAYS:

Put a smile in your telephone voice and let your personality shine!

Contact
Clarification
Closure
Completion

Focus on FEELINGS
Sensing if the caller is upset (mad or sad), confused or just wants to vent, will help the counselor know how to start the conversation. Sometimes you must start with a period of listening. Let them rant and rave. Listen for the "tone" of voice. If the caller has strong feelings, these must be acknowledged and dealt with before the call can proceed successfully.

Be SUPPORTIVE
You will be able to begin helping the caller when they believe that you want to listen and help them (even if you really don't). If they feel you support their "right" to be frustrated/confused/mad, they will believe they have found an ally who cares about them (you may be the first).

Don't allow any silences
You want to be supportive but your time is valuable (trust me, there is another caller waiting). Be ready with a question to prompt the beneficiary.

Be warm
Sometimes a friendly voice is all they need to hear - in some cases, ANY human voice is a blessing - but if we can make it a *warm* human voice, we have won half the battle. Use the caller's name. It personalizes the conversation and makes it harder for the caller to attack you. (Besides, EVERYONE likes to hear the sound of his or her own name.)

Smile
You would be surprised how a smile transmits over the phone - it can be "seen" and more importantly, felt by the caller. If you're not sure how to smile at no one, practice in the mirror so you will know how it feels.

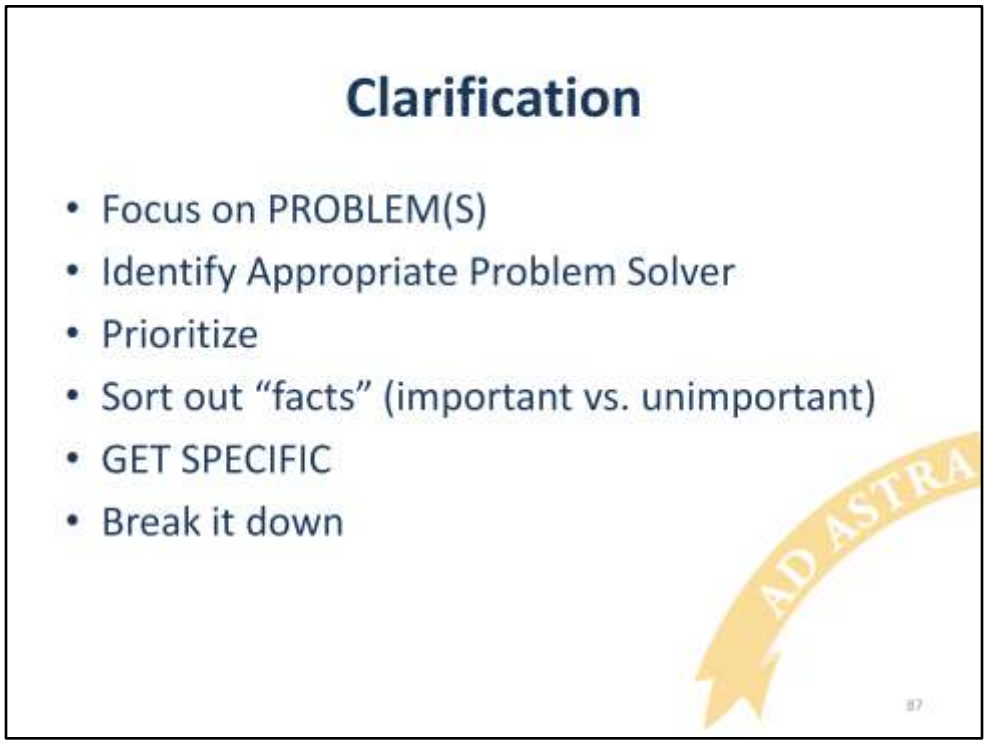
Make "eye contact"
Just like your smile is being "seen" - eye contact can be felt - it also helps to intensify your concentration if you envision the caller. If you are reading something, like the Internet, while

talking to a caller, it will be very obvious that you are distracted. They deserve your full attention.

Keep it personal (them, not you)

Often, it is very easy to "identify" with the caller's situation. Honestly, they do not care about you and your problems. It probably won't make the caller feel any better to know there is someone worse off than they are. This is THEIR problem, this is affecting THEM personally - focus on the caller 110%.

The COUNSELOR has two basic goals with this part of the call - 1) establish some rapport (see def.); and 2) begin to find out what *really* is their problem.



Focus on PROBLEM(S)
Something has triggered this person to call us. It might be that someone told them to call us because "those SHICK people know everything." Or someone may have just picked our number at random. At any rate, by the time we get to this point in the call we should know the basic reason for the call or the problem that needs to be addressed.

Identify Appropriate Problem Solver
"It" may not be you! If you don't know - don't make up an answer.
If that means giving them another number to call; transferring; or taking their name and number and having someone else call them back, do it!
The caller's concern/problem may be very complicated – i.e. a retired veteran whose recently divorced spouse has end-stage renal disease who didn't know they could sign up for Medicare, who never signed up for Part B, who just lost a job with insurance, who now qualifies for COBRA, and needs help with prescription drug expense.

Prioritize
Multiple problems can easily "crop up" with each call. Seldom is there one simple problem. Prioritize based on the most "urgent" problem.

Sort out "facts" (important vs. unimportant)
Someone to talk to - is sometimes the MAIN reason for the call - but if you have determined there is a problem to solve or an issue to address, begin sorting the facts. The number of pets and grandchildren a caller has seldom has a bearing on getting to a solution. Once you know the #1 problem to be solved (hopefully today) there should be information that you KNOW you need.

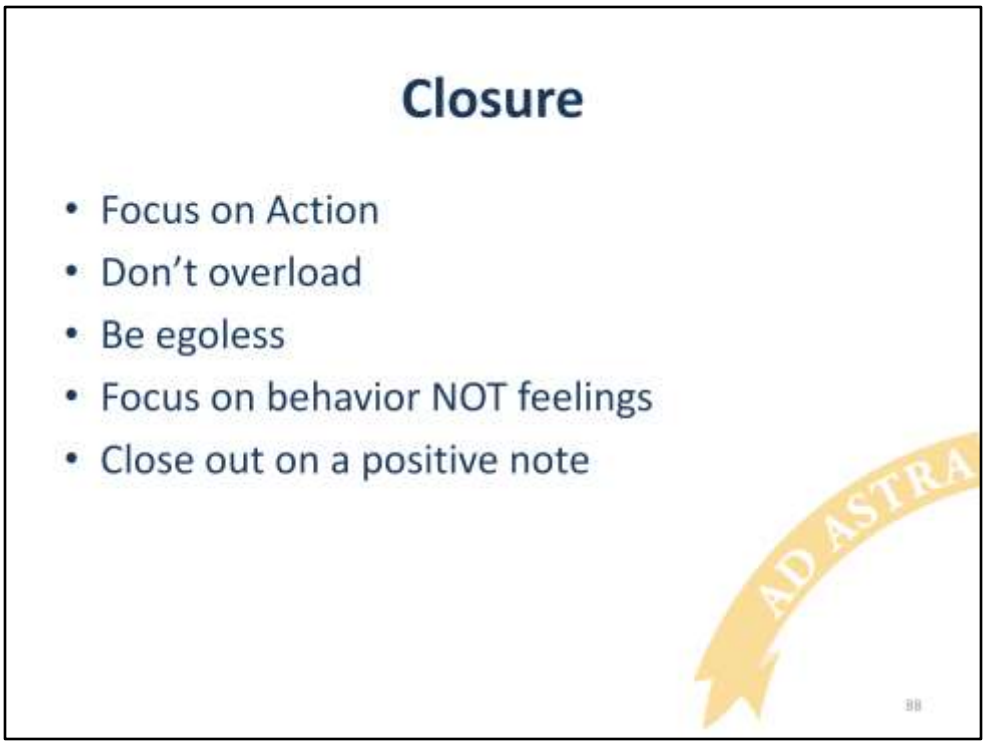
GET SPECIFIC
Some questions are cut and dried. The best solution may depend on multiple answers in relationship

to each other. DON'T be SNOOPY or GOSSIPY - just the facts - in as much detail as you feel you need to get to that "best solution" or "to see all the options."

Break it down

Be sure you understand the information and the relationship of the information you have collected. Dates can be particularly confusing.

How you answer/solve/address/respond to the caller's inquiry depends on the information you have gathered. One little piece of misinformation can greatly change your answer. For example, assuming the caller is 65 or older when really they are under 65 and disabled.



Focus on Action

"Just Do It!" Transfer the call; refer the call; mail a publication; answer a simple question - take some kind of action - the caller will appreciate ANYTHING you DO for them.

Don't overload

In an effort to be helpful, it is easy to give out too much information. There is so much we want to share. Remember, what seems like a simple concept to us may be overwhelming and hard-to-grasp information to the caller. Keep It Simple!

Be egoless

This isn't about us - this is about the caller and their problem/question/concern - sympathize and empathize, but focus on their situation - as far as they know, their problem/concern may be the worst thing that has ever happened to anyone and no question is ever a dumb question. FOCUS - what do THEY need to do know to help themselves? What can I do to be of any further assistance?

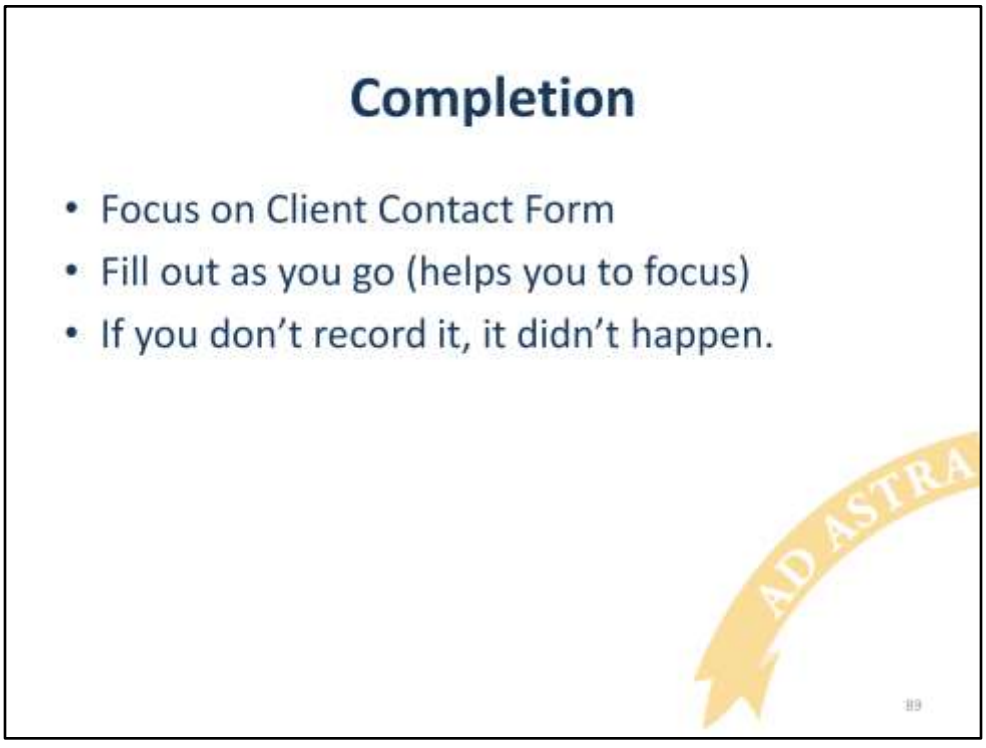
If the caller uses phrases, which begin like this: "You People…" Remember, they do not know what a nice person you are - this is not a personal attack - they might just be frustrated beyond belief - put yourself in their shoes. Smile and listen.

Focus on behavior NOT feelings -

Again, ACTION is the key - what do we/they need to do next? How we feel is not important - how they feel is important, but secondary - what can be done to move toward solving their dilemma today and moving on to the next caller is the #1 priority.

Close out on a positive note

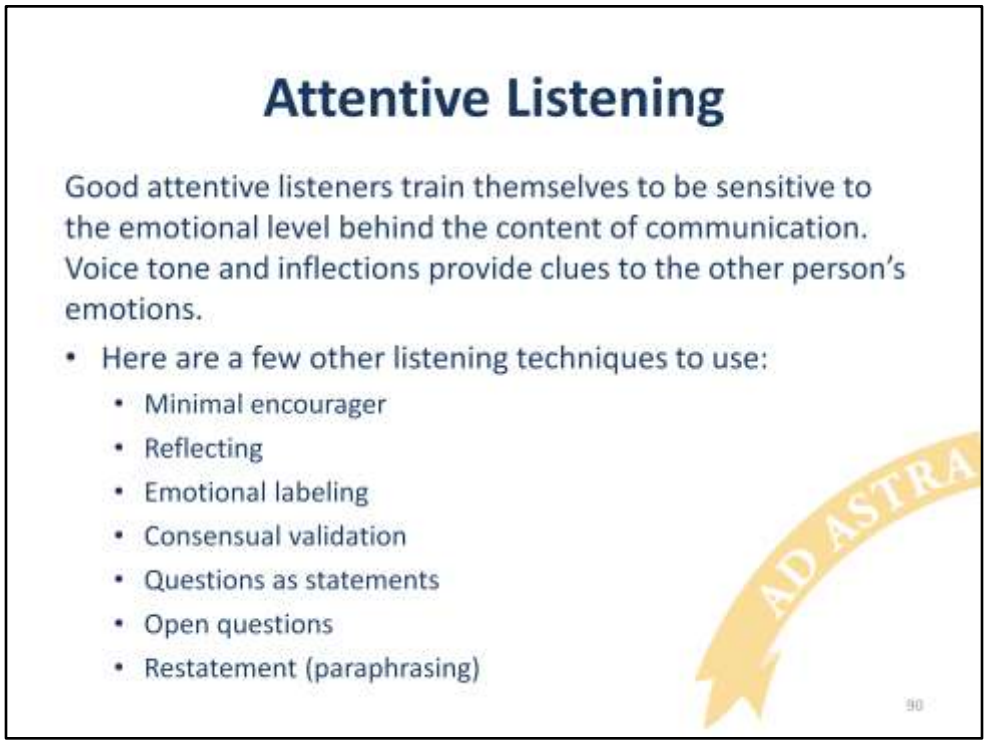
Leave them with the feeling that they are better off because they called and got you. Think again about why you are answering the phone - you could be their last hope. Even if you have been totally unsuccessful with assistance, their situation appears hopeless and your hands are tied, you can close the call by saying something positive. At least they will hang up believing that you care.



Focus on Client Contact Form
When you make a to-do list and check off the things that you have done, this action gives most of us a feeling of satisfaction, accomplishment. Filling out a Client Contact Form helps us to realize how much good the SHICK counselors and program are doing. At the end of the year, it is gratifying to look at the "number of beneficiaries served" and know that we had a hand in helping all these people. If the form is not completed, they cannot be counted.

Fill out as you go (helps you to focus)
To attentively listen, taking notes is your best technique - it will help you focus on the caller and their situation. When focusing, taking notes often helps to block out distractions. When you take notes, use the Client Contact Form, you can submit that form or transfer information to Online Client Contact Form. Often the caller answers the questions on the form in their conversation, saving you the necessity of asking each question. If you are taking notes, you will have much of the information you need to help you see all of the caller's options -so you can make suggestions - so they can make an informed decision.

"If you don't record it, it didn't happen.
If, in fact, the call is NOT recorded on a Client Contact Form, then it did not happen - you did not spend your valuable time talking with this individual - you did not help them - they do not exist in the SHICK world.



Attentive Listening

Good attentive listeners train themselves to be sensitive to the emotional level behind the content of communication. Voice tone and inflections provide clues to the other person's emotions.

Here are a few other listening techniques to use:

Minimal Encourager

These are conversational fragments like "ah ha", "yes", "I see" and "hmmm". These are regularly and often unconsciously used to keep a conversation going. They can be especially useful during the early, "contact" phase of the call. The caller needs encouragement to continue. These help with those painful silences that can happen and helps the caller know you are still listening.

Reflecting

A keyword, phrase or sentence is repeated to verify what you heard.

Emotional Labeling

This means identifying important emotions, which may not always be expressed directly, and then labeling them for the caller's benefit. Understand the difference between telling the caller how they are and how they sound.

Try to be as precise as possible. A really attentive listener can identify degrees of emotion. For example, consider the difference between annoyance, anger and fury. An upset or frustrated person is often unable to move ahead toward problem solving until the feelings behind the problem have been recognized and dealt with.

Consensual validation

After emotions are recognized, consensual validation gives the reassurance that it is okay to feel that way. This technique may be used to offer reassurance that someone's feelings aren't "bad" or "crazy."

Questions as statements

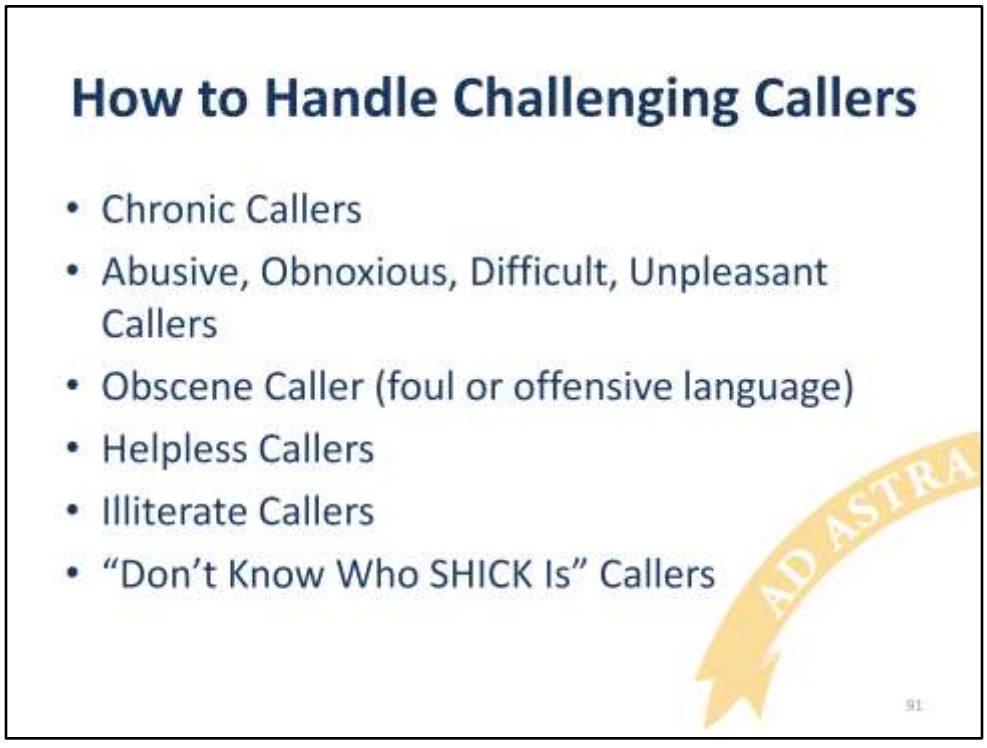
Sometimes it may take a lot of questions to get to the "bottom of things." Asking questions in a rapid-fire sequence may sound like the 3rd degree. To avoid this some questions can be phrased as statements.

Open Questions

These questions cannot be answered with "yes" or "no". Frequently these begin with "what," "why," "where," "when," or "how". Open questions can be used by the counselor to explore feelings or motivations. They can also be used when the counselor is asked their opinion.

Restatement

Restatement or paraphrasing is often used to acknowledge and summarize important feeling and/or facts.



Chronic Callers

These are people who repeatedly call with issues, some of which sound legitimate, but you have tried to help them before and you were not successful. Sometimes these people just wanted to vent, sometimes they just want someone to talk to. Often you have given them "options" in the past, but they have chosen to do nothing, or possibly they are unable to do anything for themselves and there is no one to assist them. (No family, case worker, etc.) Possibly they have alienated anyone who may have been of real hands-on assistance.

Abusive, Obnoxious, Difficult, Unpleasant Callers

Here are some coping suggestions:

Fogging = Agreeing

Broken Record = Repeat the same phrase again and again

Deferring attention = set an appointed time to call them back - and do it - this may defuse their attitude (Be careful, this could make them worse)

Look for hurt/frustration- anger might only be the symptom, deal with the REAL cause

Use Interruptive = "Excuse me", "Just a minute please", "Slow down a minute please", "I'd like to say something please"

THEN Focus on REAL Problem with:

"You seem especially concerned about_____ and I'd like to pay attention to that."

When you hang up, remember "out of sight, out of mind." Don't let an angry caller ruin your day.

Obscene Caller (foul or offensive language)

If you are offended by foul language, and often it's a barrier to being able to solve the problem, say that if they persist, you will hang up and then **HANG UP**. (Please document this on a Client Contact Form.) Often, when you hang up, the person calls back and apologizes.

Example: “Excuse me; I can’t help you if you insist on using that type of language. If you continue, I will hang up.”

Helpless Callers

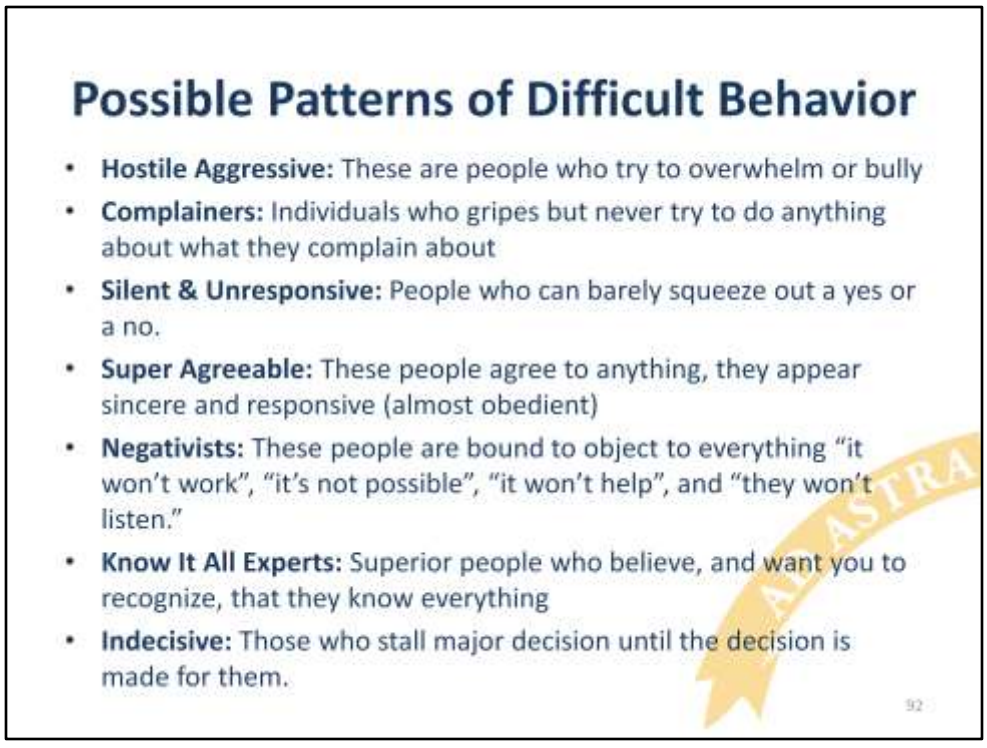
The caller exhibits tendency of being helpless, always asking for and often expecting help. Talk about “their responsibility and reinforce/repeat every positive action that they can/should take.” This is often called self-advocacy.

Illiterate Callers

These callers may not be able to read and/or write. These people may not be able to record/write down the information given to them, so they may ask for the counselor to repeat several times in order to memorize the information. Due to embarrassment, they may not mention at the beginning of the call that they have this special challenge. Patience is the keyword here. It may be necessary to ask if there is someone else in the room that may assist, talk with you, or write down the information for the caller. According to the dictionary an illiterate person can also mean, “ignorant of the fundamentals of given art or branch of knowledge.” For example, “insurance illiterate.” This person presents a whole new set of challenges - if they do not understand basic concepts of insurance such as deductibles and coinsurances, patience again will be necessary to work through this call. There are some definitions that must be understood before more complex concepts can be explained. The counselor must listen for clues of misunderstanding or “illiteracy” of all kinds.

“Don’t Know Who SHICK Is” Callers

These callers have been referred to SHICK because they need assistance. The referral is often from a caseworker or social worker that is not completely familiar with SHICK; they just know that we help people get assistance. Ergo, the beneficiary believes that SHICK = Free Drugs or Drug Insurance. They may sound confused when you answer the phone. They may start out by saying, “I want to sign up for SHICK.” It is appropriate to explain what SHICK is and then to continue to explain the Medicare Prescription Drug Program.



Hostile Aggressive: These are people who try to overwhelm or bully by bombarding others, making cutting remarks or throwing tantrums when things do not go their way.

Sherman Tank - Comes on charging - Open attack
Sniper - Takes pot shots - Launches verbal missiles
Exploder - Makes sudden response

Complainers: Individuals who gripes but never try to do anything about what they complain about, either because they feel powerless or because they refuse responsibility.

Whiners - Singsong quality
Triangular - Complains to you, but not at you - try to get you to agree

Silent & Unresponsive: People who can barely squeeze out a yes or a no.

Clams - Have a tendency to close down

Super Agreeable: These people agree to anything, they appear sincere and responsive (almost obedient) - BUT they do not do what you suggested as one of their options and often they act contrary to your suggestion and take the opposite action.

Negativists: These people are bound to object to everything "it won't work", "it's not possible", "it won't help", and "they won't listen."

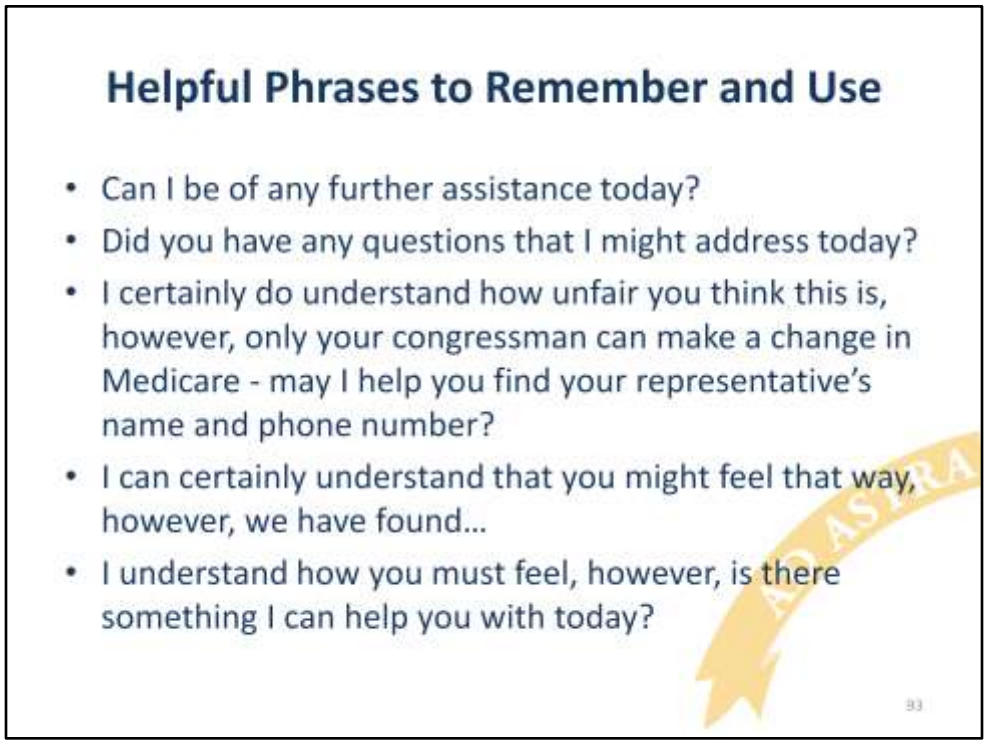
Wet Blanket Power - It just won't work…
Yes But-ter - Yes, but…

Know It All Experts: Superior people who believe, and want you to recognize, that they know everything there is to know about anything worth knowing. They can be condescending, imposing or pompous - they will likely make you feel like an idiot or at least try.

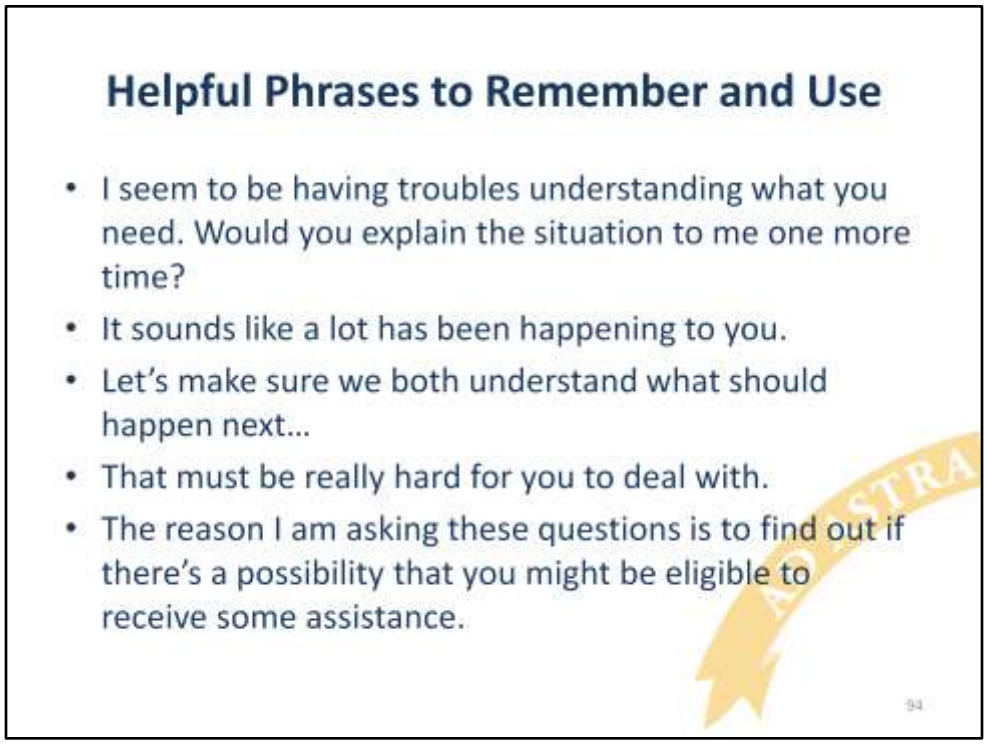
Bulldozers - Push their ideas and/or opinions
Balloons - "know-it-all" expert - full of hot air…

Indecisive: Those who stall major decision until the decision is made for them. Those who have to think and think won't let go unless everything is perfect.

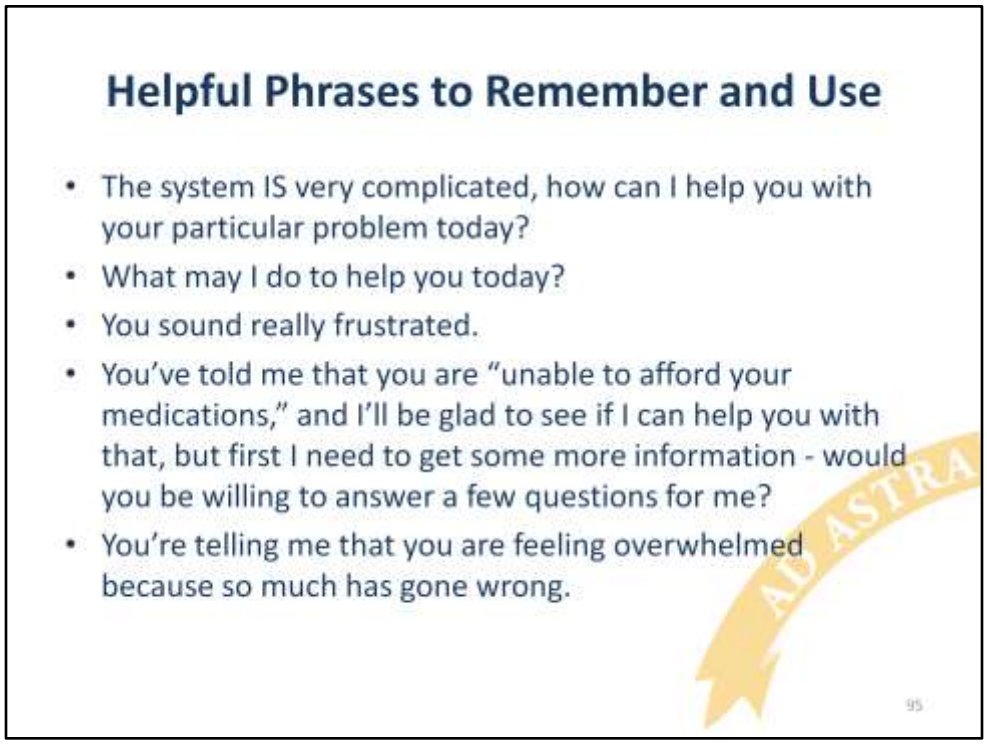
Staller - Maybe…We'll see…I'm not sure…



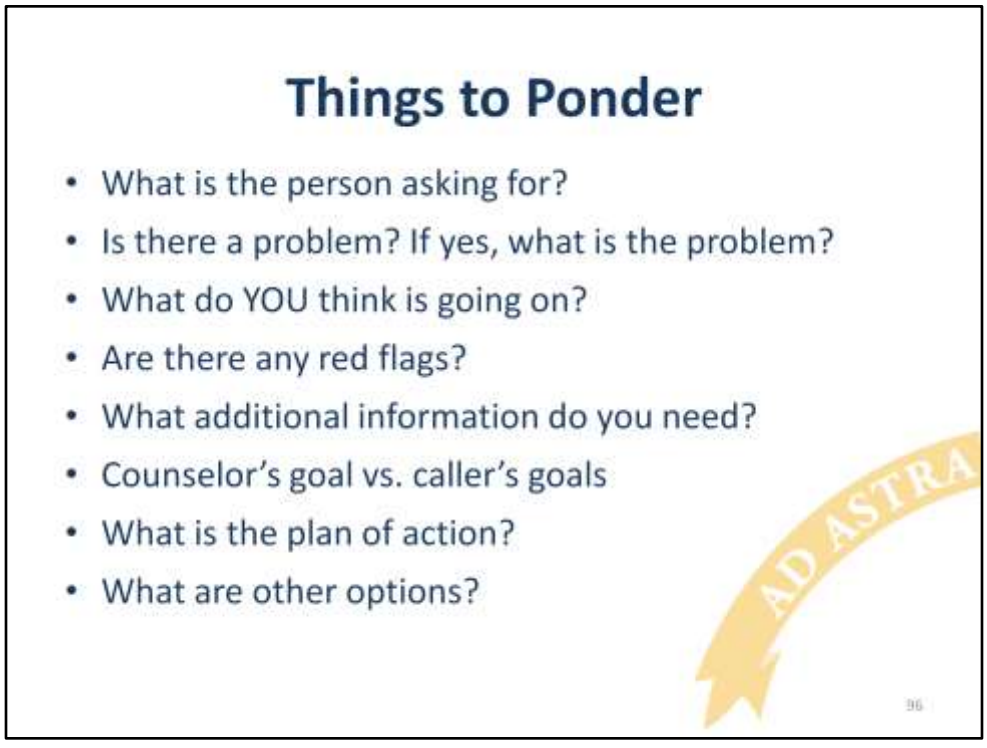
- Can I be of any further assistance today?
- Did you have any questions that I might address today?
- I certainly do understand how unfair you think this is, however, only your congressman can make a change in Medicare - may I help you find your representative's name and phone number?
- I can certainly understand that you might feel that way, however, we have found…
- I understand how you must feel, however, is there something I can help you with today?



- I seem to be having troubles understanding what you need. Would you explain the situation to me one more time?
- It sounds like a lot has been happening to you.
- Let's make sure we both understand what should happen next…
- That must be really hard for you to deal with.
- The reason I am asking these questions is to find out if there's a possibility that you might be eligible to receive some assistance.



- The system IS very complicated, how can I help you with your particular problem today?
- What may I do to help you today?
- You sound really frustrated.
- You've told me that you are "unable to afford your medications," and I'll be glad to see if I can help you with that, but first I need to get some more information - would you be willing to answer a few questions for me?
- You're telling me that you are feeling overwhelmed because so much has gone wrong.



What is the person asking for?

Is there a problem? If yes, what is the problem?

What do YOU think is going on?

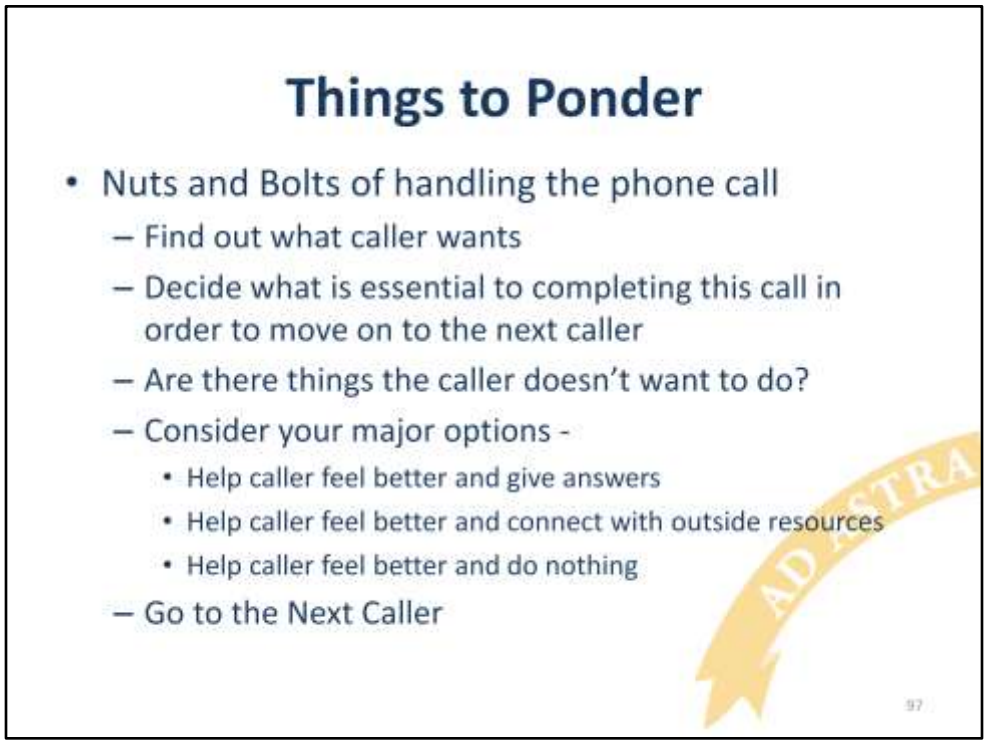
Are there any red flags?

What additional information do you need?

Counselor's goal vs. caller's goals

What is the plan of action?

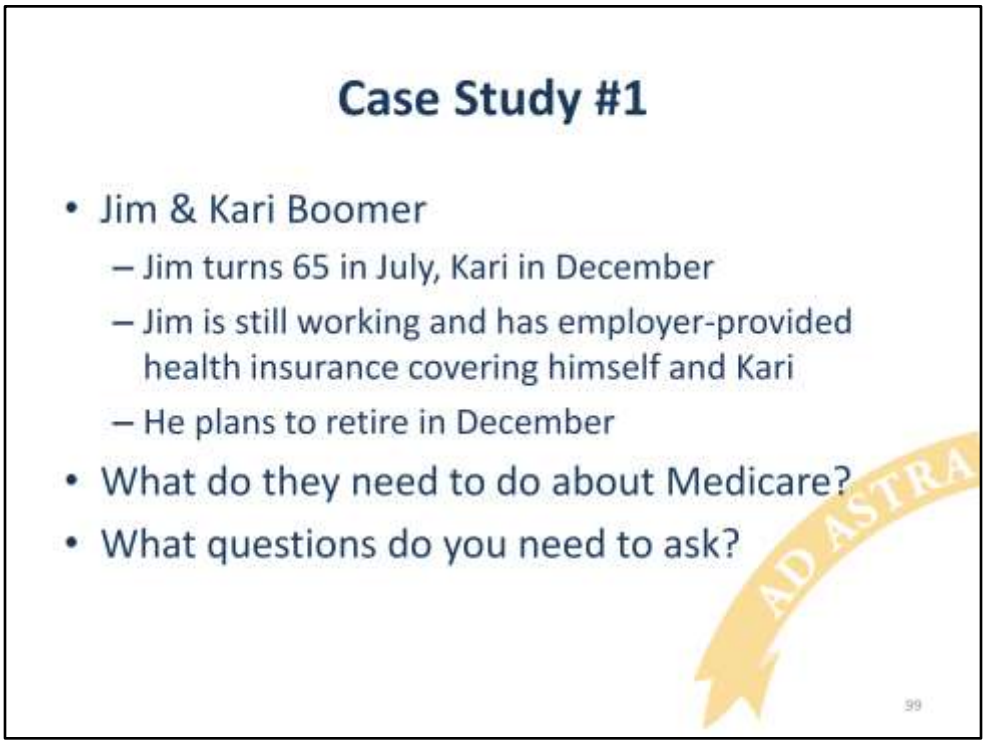
What are other options?



- Nuts and Bolts of handling the phone call
    - Find out what caller wants
    - Decide what is essential to completing this call in order to move on to the next caller
    - Are there things the caller doesn't want to do?
    - Consider your major options -
        - Help caller feel better and give answers
        - Help caller feel better and connect with outside resources
        - Help caller feel better and do nothing
    - Go to the Next Caller

MEDICARE CASE STUDIES

- We will review the following case studies and discuss various solutions
  - #1 - Jim & Kari Boomer
  - #2 - Elmer Windsor
  - #3 - Linda Oliver



Jim & Kari Boomer

- Jim turns 65 in July, Kari in December
- Jim is still working and has employer-provided health insurance covering himself and Kari
- He plans to retire in December

What do they need to do about Medicare?

What questions do you need to ask?

Case Study #1 Notes

Does Jim want to enroll in Medicare Part A, Part B, or both? Does he need to enroll in Medicare Part D prescription drug plan (PDP)?

Is Jim already claiming SSA retirement benefits? If so, SSA will automatically enroll him in Medicare Part A and Part B. Jim will have to decide if he wants to waive enrollment in Part B.

Jim should check on whether his employer group health plan (EGHP) will be primary or secondary to Medicare.

If his employer has 20 or employees, his EGHP would be primary to Medicare. Medicare will pay on his health claims only if the amount paid by his EGHP is less than what Medicare would have paid as primary. Then it will pay the difference between the amount paid by the EGHP and the Medicare approved amount. **Jim may want to enroll in Part A only, and delay enrolling in Part B until he leaves the EGHP based on his active employment. He will get a special enrollment period (SEP) of eight months after losing a EGHP based on active employment. His Part B coverage will begin the first of the month after enrollment.**

If Jim has a high-deductible health plan (HDHP) with a Health Savings Account (HSA), he might want to also delay enrollment in Part A if he isn't currently receiving SSA retirement benefits. He would not be able to contribute to an HSA if he is enrolled in Part A.

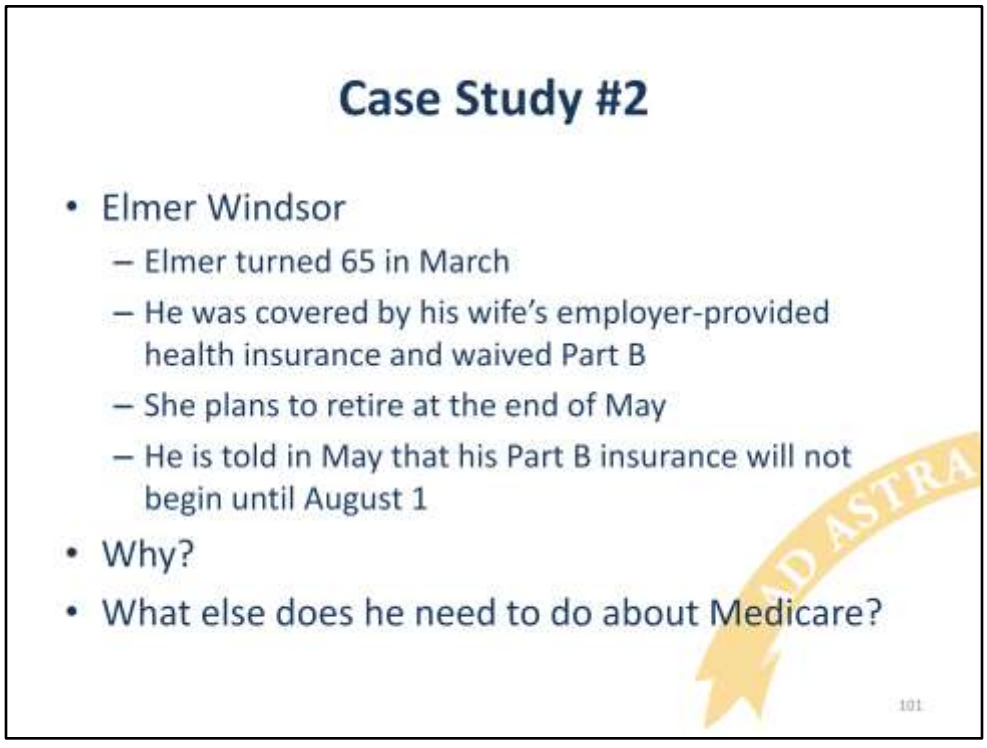
If his employer has less than 20 employees, Medicare will be primary to the EGHP. **Jim will probably want to enroll in Part A & Part B because his EGHP would probably not pay claims until Medicare had paid first.**

Another question to ask is if Jim is eligible for Tricare. If a beneficiary is eligible for Tricare, Tricare requires that they must be enrolled in Medicare Part B to keep their Tricare.

Jim also needs to verify if he has creditable prescription drug coverage through the EGHP. If it is not creditable, he may want to enroll in a Part D PDP or risk incurring a premium penalty later.

What should Kari do?

As long as Jim keeps his EGHP until retirement in December, Kari should probably enroll in Medicare when she is eligible in December.



Elmer Windsor

Elmer turned 65 in March

He was covered by his wife's employer-provided health insurance and waived Part B

She plans to retire at the end of May

He is told in May that his Part B insurance will not begin until August 1

Why?

What else does he need to do about Medicare?

Case Study #2 Notes

Why was Elmer's enrollment in Part B delayed?

Elmer was still within his seven-month Initial Enrollment Period (IEP). It began December 1, and continued through June 30.

If he had enrolled in the three months prior to his birthday month, his Part B would have started March 1. If he had enrolled during his birthday month, his Part B would have begun April 1. If he enrolls in the three months after his birthday, his Part B will be delayed.

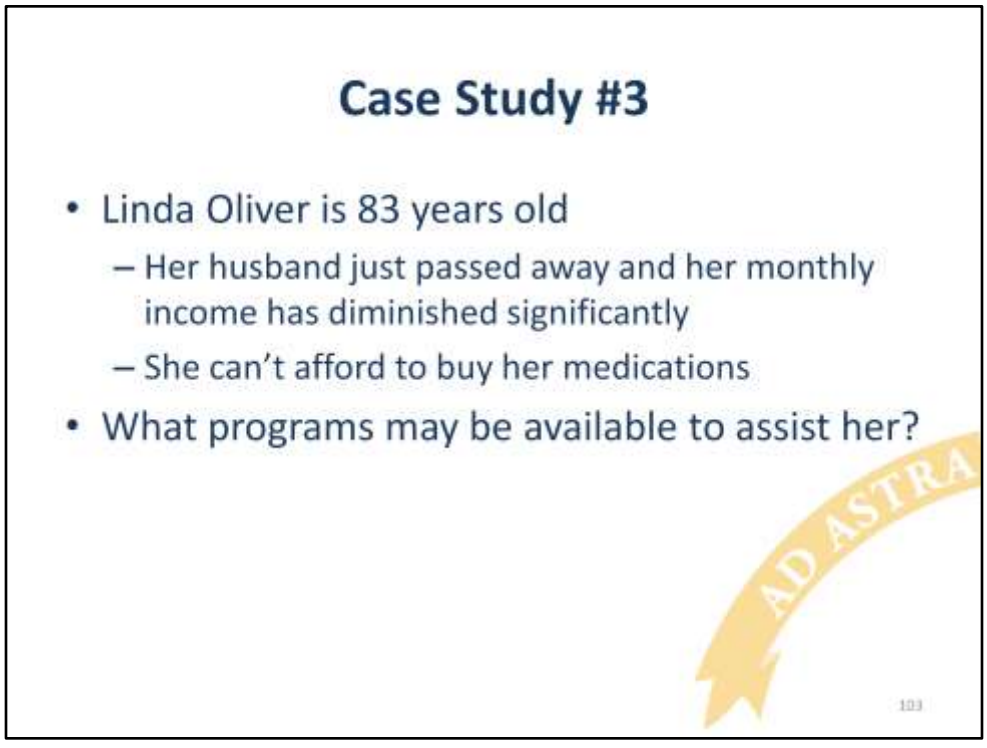
Enrollment in the first month after his birthday month, Part B will be delayed for two months. This means if he enrolled in April, his Part B enrollment would be delayed until June 1. If he enrolls in either the second or third month after his birthday month, his Part B enrollment will be delayed for three months. Therefore, a May enrollment will delay the start of Part B until August and a June enrollment will delay the start of Part B until September 1.

Why doesn't he get an eight-month SEP for Part B after losing EGHP due to loss of active employment(his wife's)?

The Initial Enrollment Period (IEP) takes precedence over Special Enrollment Periods. Because he was still in his IEP, those provisions took precedence over the SEP provisions.

Can he enroll in Part D with a June 1 effective date?

Yes, he can enroll in Part D with a June 1 enrollment date because he is within his IEP and there is no enrollment delay for Part D.



Linda Oliver is 83 years old

- Her husband just passed away and her monthly income has diminished significantly
- She can't afford to buy her medications

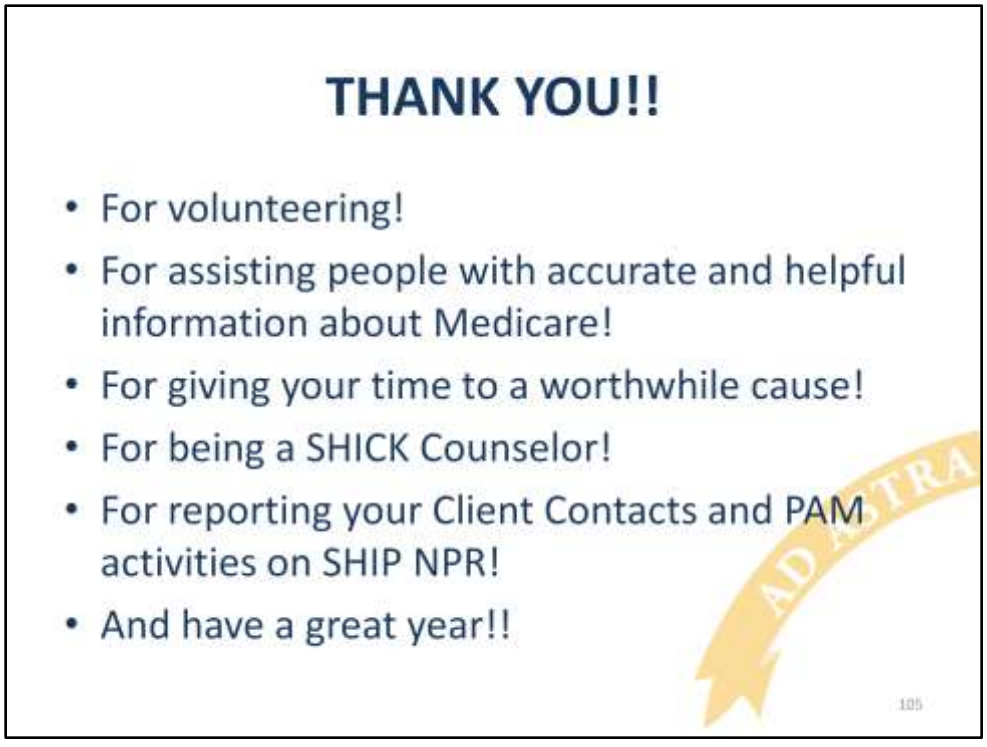
What programs may be available to assist her?

Case Study #3 Notes
What assistance may be available for Linda?

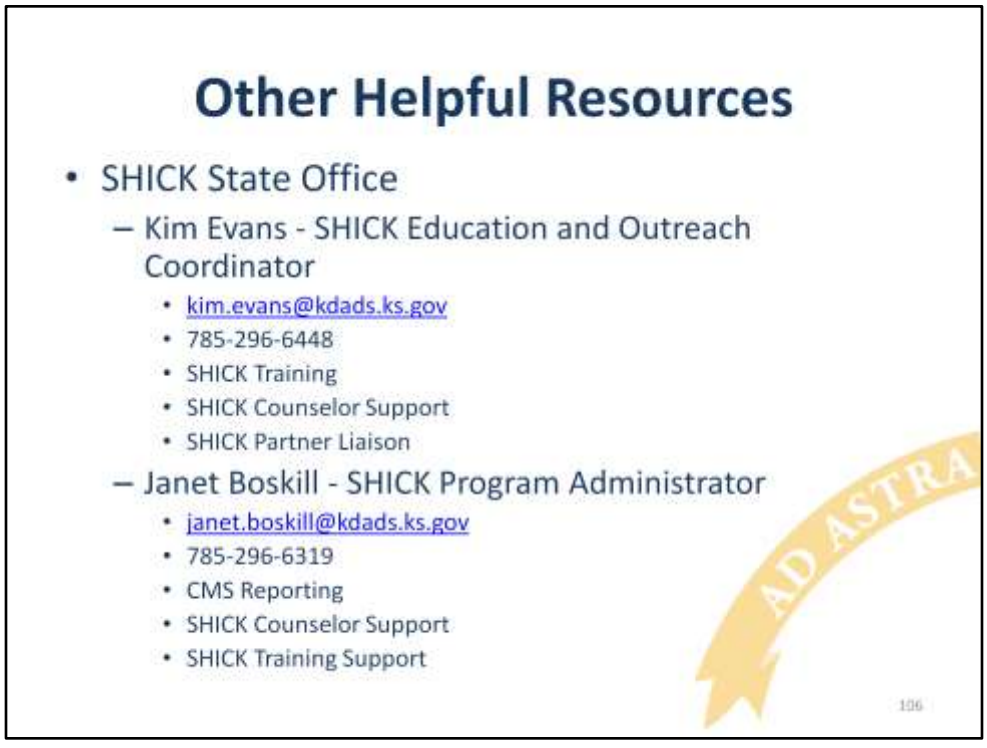
Medicaid
Medicare Savings Program (MSP)
Low Income Subsidy (LIS) or Extra help through SSA
Pharmacy Assisstance Programs (PAPs)

She may qualify for a larger SSA benefit (widows) or for a widow's pension from the VA if her husband was a veteran.

Department of Veterans Affairs benefit - Aid and Attendance and Housebound Improved Pension benefit (http://www.benefits.va.gov/pension/)



For volunteering!
For assisting people with accurate and helpful information about Medicare!
For giving your time to a worthwhile cause!
For being a SHICK Counselor!
For reporting your Client Contacts and PAM activities on SHIP NPR!
And have a great year!!



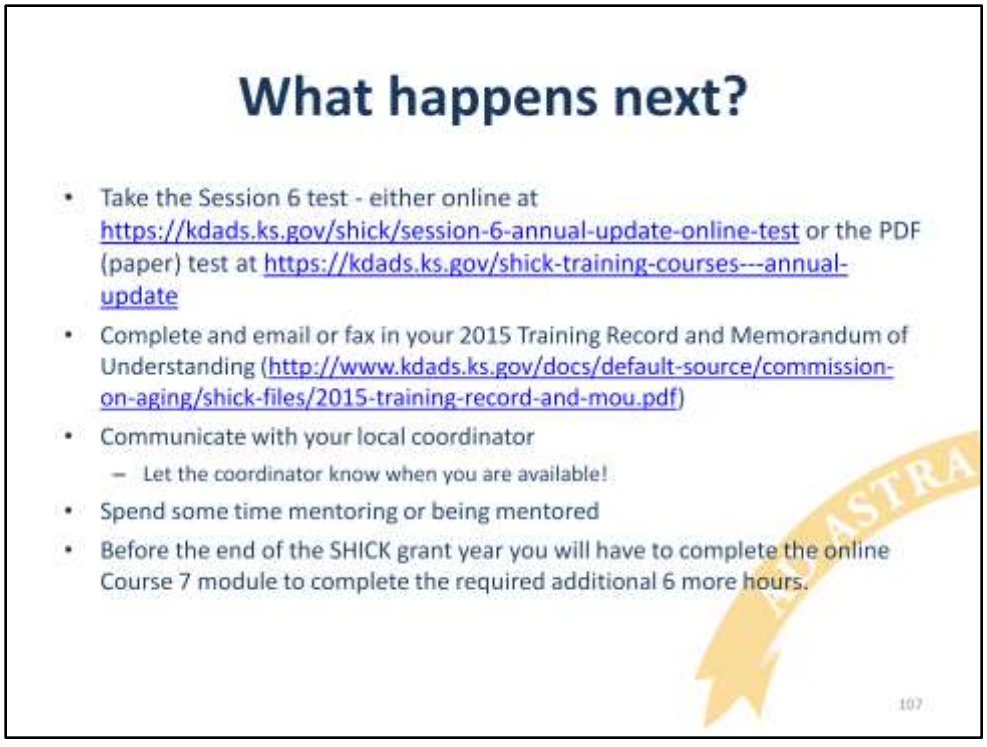
SHICK State Office

Kim Evans - SHICK Education and Outreach Coordinator

kim.evans@kdads.ks.gov
785-296-6448
SHICK Training
SHICK Counselor Support
SHICK Partner Liaison

Janet Boskill - SHICK Program Administrator

janet.boskill@kdads.ks.gov
785-296-6319
CMS Reporting
SHICK Counselor Support
SHICK Training Support



- Take the Session 6 test - either online at https://kdads.ks.gov/shick/session-6-annual-update-online-test or the PDF (paper) test at https://kdads.ks.gov/shick-training-courses---annual-update
- Complete and mail in your 2015 Training Record and Memorandum of Understanding (http://www.kdads.ks.gov/docs/default-source/commission-on-aging/shick-files/2015-training-record-and-mou.pdf)
- Communicate with your local coordinator
  - Let the coordinator know when you are available!
- Spend some time mentoring or being mentored
- Before the end of the SHICK grant year you will have to complete the online Course 7 module to complete the required additional 6 more hours.